DOCKET NO. HHD CV 16 6067438	:	SUPERIOR COURT
JOSHUA ISAAC MONROE LYNCH, PPA, ET AL	:	J.D. OF HARTFORD
VS.	:	AT HARTFORD
STATE OF CONNECTICUT, ET AL	:	AUGUST 27, 2021

CORRECTED AND RECONSIDERED

MEMORANDUM OF DECISION

COURT TRIAL

I

BACKGROUND

The plaintiffs in the medical malpractice action allege that twin fetuses were exposed to cytomegalovirus (CMV) in donor sperm during an intra uterine insemination (IUI) procedure, performed on May 11, 2014, at the University of Connecticut Health Center's (UCONN) Center for Advanced Reproductive Services (CARS). The plaintiffs allege malpractice by the defendant resulted in the death of one twin child, Shay, and debilitating, life-long medical conditions in the other twin, Joshua, caused by exposure to CMV in utero. This matter was heard by the court in a virtual courtroom setting pursuant to Practice Book § 23-68, with evidence beginning on

344

ECC: Rptr. Judicial Decisions
8/27/21

November 3, 2020, and ending on December 18, 2020.[1] After careful consideration of the evidence and applicable law, the court finds for the plaintiffs.[2]

The plaintiffs are Jean-Marie Monroe-Lynch, the biological mother of fraternal twins; namely, Joshua and the estate of Shay Monroe-Lynch. In addition, Aaron Lynch is a plaintiff. He is Ms. Monroe-Lynch's husband and the legal father of both children. At the time of the delivery of Joshua and Shay, Ms. Monroe-Lynch was a thirty-four year old woman with a Master's Degree in clinical social work and, at the time of trial, employed by the Wheeler Clinic. Aaron was a thirty-one year old trans-male[3] with a Master's Degree in education and, at the time of trial, was employed as a special education teacher. Ms. Monroe-Lynch and Aaron were unable to procreate children together and so, in the late summer of 2013, they decided to approach the defendant, CARS, for Therapeutic Donor Insemination (TDI) services.[4]

There are two general theories of liability set forth in the revised complaint, dated February 25, 2019.[5] First, that the defendant committed malpractice based upon negligent fertility treatment, alleging that the defendant did not properly inform Ms. Monroe-Lynch and knowledgably obtain her consent regarding the risks associated with a CMV infection while participating in the TDI process.[6] Specifically, the plaintiffs allege the defendant failed to inform

---

[1] See *Monroe Lynch* v. *State*, Superior Court, judicial district of Hartford at Hartford, Docket No. CV 16 6067438 (September 11, 2020, *Taylor, J.).*

[2] The proffering of evidence was liberally permitted, with admissibility and relevance reserved in some instances for the court's final decision, as reflected in this memorandum of decision.

[3] The issue of Aaron's gender assignment at birth is relevant, only because he could not have transmitted CMV to Jean-Marie by semen during sexual intercourse.

[4] Exhibit 5.

[5] The defendant answered this complaint on June 3, 2020. No special defenses were filed. Entry # 225.

[6] Counts one through four of the revised complaint, dated February 25, 2019, allege this cause of action for lack of informed consent by each of the four plaintiffs, including count two on behalf of the estate of Shay. Counts five and six are alleged under this theory by Aaron for filial consortium as to Joshua, the surviving twin, and Shay who passed away in utero. Counts seven

them of the risk of infection in choosing a sperm donor whose blood tested positive for CMV antibodies (IgG positive), while Ms. Monroe-Lynch tested negative for CMV antibodies (IgG negative) in bloodwork performed when she began the TDI process in September of 2013.

The second general theory of liability alleged in the revised complaint, dated February 25, 2019, is that the defendant committed malpractice based upon negligent prenatal treatment, in that it failed to properly detect and respond to abnormal findings during Ms. Monroe-Lynch's ultrasound procedure on October 2, 2014, while in her twenty-second week of pregnancy. The plaintiffs allege that the defendant otherwise failed to properly assess and investigate the cause of these findings, including a possible CMV infection, before the twin fetuses became viable and, thereby, precluding their choice of terminating the pregnancy, which they otherwise would have exercised.[7]

The foundational dispute between the parties revolves around causation. The defendant disputes both the causation of the plaintiff's CMV infection, as well as the causation of Joshua's claimed medical conditions.[8] Although it is undisputed that CMV is a sexually transmitted disease and that it is *theoretically* possible to transmit the disease during a TDI procedure such as IUI, the defendant contends this has yet to be conclusively proven as a matter of scientific fact. Specifically, there has been no reported case of donor sperm, which has been "washed" for

---

and eight are brought by Jean-Marie under the same theory as five and six, but in her own right. Counts nine and ten are brought by Aaron and Jean-Marie, respectively, for negligent infliction of emotional distress.

[7] Counts eleven through thirteen allege this cause of action by each of the three living plaintiffs, Joshua, Aaron and Jean-Marie, respectively. Counts fourteen and fifteen are alleged under this theory by Aaron and Jean-Marie, respectively, for filial consortium as to Joshua, the surviving twin. Counts sixteen and seventeen are brought by under the same theory by Aaron and Jean-Marie, respectively, for negligent infliction of emotional distress.

[8] It is undisputed that Shay expired due to a CMV infection.

insemination, linked to a CMV infection in either a sperm donor recipient or her fetus. In addition, the parties dispute the causation related to damages asserted by the plaintiffs, particularly as they relate to Joshua's congenital CMV.

The court will first address the question of the causation of the plaintiffs' CMV infections before addressing other disputed issues of negligent fertility treatment. Absent causation, for example, the claim of a failure to inform the plaintiffs of the risk of CMV infection would be nullified. The court will then address the appropriate standard of care for doctors specializing in Reproductive Endocrinology and Infertility (REI). Regardless of a finding of causation resulting from the IUI procedure performed on May 11, 2014, the court will then address the claims of negligent prenatal treatment and the standard of care for Maternal Fetal Medicine (MFM) and Obstetrics and Gynecology (OB/GYN). The court will then proceed to the question of damages.

II

CAUSATION

A

Ms. Monroe-Lynch's CMV Infection

Evaluating evidence of causation is challenging because CMV, like many pathogens, is both an unseen and relatively ubiquitous virus. Some facts regarding CMV are nonetheless clear and uncontroverted. Evidence in the record reveals that CMV is a common herpes virus, infecting well over 50% of the general population.[9] It is undisputed that CMV may be sexually

[9] "So, well, you know, the -- by age 40, about half, a little over half of adults in the United States have CMV antibody, the important caveat being that there are some differences based on race, ethnicity, socioeconomic status, geographic region. But it's over 50 percent." Tr. of Dr. Schleiss, 12/10/2020 a.m., p. 16.

transmitted among adults through the sharing of bodily fluids such as saliva, urine, semen and other secretions of reproductive organs. Although inapplicable in the present matter, it may also be transmitted between an infected mother and infant through breast feeding.[10] It may also be transmitted by, so-called, "community spread" through physical contact with bodily fluids, most notably by contact with urine and saliva. In adults, however, CMV is primarily transmitted through genital fluids such as semen and intimate sexual contact.[11] Although a CMV infection rarely results in serious illness among adults, an infection in a fetus during early pregnancy may result in profound, life-altering health consequences as occurred in the present matter.

Antibodies associated with an initial CMV infection are identified as IgM, as opposed to IgG. There is also no dispute that Ms. Monroe-Lynch was both IgM and IgG negative for CMV when she began the TDI program at CARS in September 2013, but became infected with CMV by the time of the twins' delivery on January 13, 2015.[12] It is undisputed that Joshua and Shay contracted CMV during Ms. Monroe-Lynch's pregnancy and that the pregnancy resulted from a successful IUI procedure conducted at CARS on May 11, 2014. Finally, it is undisputed that a CMV infection caused Shay's death, in utero, and the overwhelming evidence shows that Joshua continues to suffer from Congenital CMV. Exhibits 50 & 51 at p. 4, b. 1044.

---

[10] Dr. Schleiss opined that breast milk and feeding are the primary modes of CMV transmission, as follows: "Well, in all of human history, 40,000 years of evolution, you know, the most common way that CMV's been transmitted is by breast milk, that's probably the most common, and by saliva; it's the salivary gland virus, that's what it was called. And so, you know, it's -- to enumerate just one body fluid would be inconsistent with the biology of the virus." Tr. of Dr. Schleiss, 12/10/2020 a.m., p. 32, ll. 2-8. This conclusion, however true, may only be applicable to infants. It is irrelevant under the facts of this case, as it is undisputed that Shay and Joshua were infected with CMV as fetuses, in utero.

[11] "In adults over 90 percent of cases are transmitted through genital fluids through direct intimate sexual contact." Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 21, ll. 14-16.

[12] Exhibits 2, 21 & 49 p. 8, b. 1028.

However, the parties vociferously dispute the cause of the plaintiffs' infection with CMV, which is entwined with the timing of Ms. Monroe-Lynch initial infection, sometime between 2013 and 2015. The plaintiffs assert that the infection was caused by the sperm sample of a CMV positive donor, # 013673, used in Ms. Monroe-Lynch's otherwise successful IUI procedure on May 11, 2014.[13] They further assert that Ms. Monroe-Lynch had no other, identifiable exposure to CVM in the entire record presented at trial.

The defendants counter that contracting a CMV infection through a TDI procedure would be a novel occurrence, especially due to the precautions taken to "wash" donors' sperm of seminal fluid and other matter more likely to carry viable virus, such as white blood cells, after which samples are then frozen before insemination.[14] Although it has been clearly established by direct evidence that Ms. Monroe-Lynch, Joshua and Shay contracted CMV in 2014, the court concludes that only circumstantial evidence supports the conclusion that the donor sperm used in the IUI procedure, conducted by CARS on May 11, 2014, caused the plaintiffs' CMV infections.

The evidence supporting a finding that the plaintiffs' initial CMV infection resulted from the IUI procedure performed by CARS is as follows: The sperm donor selected by Ms. Monroe-Lynch and her husband, Aaron, was clearly identified as IgG positive for CMV antibodies.[15] There is no existing medical, governmental or industry requirement, however, that a sperm donor

---

[13] Exhibit 17.

[14] Exhibit 566.

[15] Exhibit 17. This information and disclosure are required by the Federal Drug Administration (FDA) for tissue samples, generally, which include sperm donor samples used in TDI procedures. The medical, governmental and industry standard for determining the CMV status of all parties to TDI procedures is by serology, more commonly referred to as blood testing. Any blood tests performed showing an initial CMV infection, signified by IgM antibodies, will render a donor ineligible to participate in TDI procedures until the IgM level subsides and is replaced by IgG antibodies, signifying a past infection and the latent status of the virus.

sample used in a TDI procedure be tested for the presence of CMV.[16] Therefore, there is no direct evidence in the present case that the sample resulting in Ms. Monroe-Lynch's pregnancy was either free from or actually carrying live, infectious CMV. On the other hand, there is no direct evidence in the record that any other person with an active CMV infection or carrying IgG antibodies, was in close or intimate contact with Ms. Monroe-Lynch between the time of her initial, negative blood test in September of 2013, and the delivery of Shay and Joshua sixteen (16) months later on January 13, 2015.

Ms. Monroe-Lynch's blood test on the day of delivery is of particular importance to expert opinions, interpreting the timing and duration of her initial CMV infection. Her serology (blood) report that day revealed an IgM antibody level of 51.5, representing a current or recent CMV infection.[17] Generally, IgM antibodies remain in serology testing for approximately six to nine months, but may be detected at lowering levels in blood samples for a year or more, before fading in relation to increasing IgG antibodies.

After IgM levels diminish, previously infected individuals are identified as carrying IgG positive antibodies for the remainder of their lives.[18] Although not continuously infectious after an initial CMV infection, IgG positive individuals may shed live and infectious virus into bodily fluids, especially into the urinary tract and reproductive fluids including seminal fluid.[19] Dr. Schleiss, the defendant's expert on causation, cautioned that CMV transmission by saliva may

---

[16] The supplier of the donor samples in the present matter was California Cryobank. Consistent with common practice, it tests the blood of its donors for CMV, but does not test sperm/semen samples for CMV shed by IgG positive donors, though there is testing available to do so. Tr. of Dr. Schleiss, 12/10/2020 a.m. at p. 96, ll. 8-13, p. 97, ll. 24-27 and p. 98, ll. 1-6, p. 99, ll. 10-12.
[17] Exhibit 49, p. 8, b. 1028.
[18] Although this is generally the case, there may be rare exceptions to this conclusion.
[19] Transmission through breast feeding is not a possible cause in the present matter, as the CMV infection occurred in utero.

occur through sharing food, such as a shared cookie or beverage and that community spread need not involve intimate contact with saliva or urine.[20] The primary method of transmitting CMV among young heterosexual women, however, is by sexual intercourse.[21] Dr. McMeeking, the plaintiffs' expert, specifically opined that approximately 90% of adult CMV transmissions occur through sexual relations.[22] Without conceding that it occurred in this case, the defendant generally agrees with this point.[23]

Circumstantial evidence supports the conclusion that Ms. Monroe-Lynch's initial CMV infection occurred at or about the time of the May 11, 2014 IUI procedure, and is reflected in two Emergency Department (ED) visits by Ms. Monroe-Lynch, approximately four weeks later on June 8 and 9, 2014. On the June 8, 2014 ED visit, Jean Marie's primary complaint was for vaginal bleeding, following the onset of a rash, fearing a possible miscarriage. At that time, she presented at the New Britain Hospital ED with a rash of unknown origin, as well as respiratory issues.[24] After her initial ED visit on June 8, 2014, she returned to the ED the following day, this time at UCONN.[25] Her primary complaint appears to have been a persistent rash on her abdomen and swelling of her face, of unknown origin.[26] These symptoms are consistent with an

---

[20] Dr. Schleiss specializes in infectious disease and CMV, but his research and clinical experience is focused on pediatrics. It is interesting to note, therefore, that his view is that breast milk is the primary method of CMV transmission among children.
[21] Although there is no evidence that Jean-Marie engaged in heterosexual behavior at the time she contracted CMV, the fact remains that she received sperm from an IgG positive donor at the time of insemination. Exhibit 67, Bates 1393.
[22] Dr. McMeeking specializes in infectious diseases and his research and clinical experience is among HIV positive adults. His view is of CMV transmission is among adults, though immunocompromised. Dr. McMeeking 11/12/20 PM Session, p. 59.
[23] "There is no controversy that sexual intercourse is a very common route of CMV transmission as it involves the exchange of a variety of bodily fluids." Defendants Trial Brief, p. 34.
[24] Exhibits 44, 45 and 508.
[25] Exhibit 509.
[26] Exhibits 146-48.

initial CMV infection,[27] as posited by the plaintiffs, and it followed the otherwise successful IUI procedure using the sperm sample from donor # 013673. Notably, CARS was informed of these symptoms and they were recorded in her medical chart.[28]

Contrary to the plaintiffs' conclusion, Dr. Schleiss contends that, although the rash and swelling Ms. Monroe-Lynch experienced in June may be symptoms of an initial CMV infection, flu-like symptoms represent a stronger correlation.[29] As such, the defendants point to an earlier ED visit by Ms. Monroe-Lynch on January 15, 2014, when she presented with an influenza like illness and fever, which are symptoms more consistent with an initial CMV infection.[30] Notably, this illness occurred after her CMV negative blood test in September when she began the TDI process with CARS, but several months before the successful insemination occurred, resulting in her pregnancy with Joshua and Shay.[31] Had Ms. Monroe-Lynch's initial infection manifested itself in January 2014, the defendants conclude that she transmitted the virus, in utero, once she

---

[27] Dr. McMeeking, 11/12/2020 a.m., p. 31, ll. 1-13, p. 37, ll. 23-27 and p. 38, ll. 1-7; Tr. of Dr. Schust, 11/10/2020, p. 29, ll. 2-12.

[28] Exhibit 22.

[29] "Q Do you have an opinion within reasonable medical probability whether this presentation -- or the presentation with a rash in June of 2014 four weeks after the insemination was indicative of a CMV infection that Ms. Monroe-Lynch contracted from that insemination within reasonable medical probability?

A Yes.

Q And what is that opinion?

A I think within reasonable medical probability it wasn't a primary CMV infection.

Q And what's the basis for that opinion?

A It's not the most common presentation of a primary CMV infection. Certainly you can see rashes with primary CMV infection and they can be any kind of a rash, urticarial, et cetera, but it's not typical. And so a febrile illness with flu-like symptoms and respiratory systems would be the more typical presentation. You know, in my study here in Minnesota we've screened 17,000 newborns, and in babies that end up having CMV this is the most common history I hear by far that of a respiratory tract ailment with a fever. It's just the more common presentation. It's possible but it's not the most likely."

Tr. Dr. Schleiss, 12/10/2020 a.m., p. 78-79.

[30] Exhibit 507.

[31] Exhibit 131, b. 16879.

was impregnated four months later, as significant IgM levels representing an active infection may last for six to nine months. Militating against the defendant's position, however, is that a mother's infectiousness due to an initial infection diminishes over time, and yet Ms. Monroe-Lynch showed a significant IgM level one year later at the time she gave birth.[32]

The defendants' causation expert, Dr. Schleiss, concludes it is likely that Ms. Monroe-Lynch was infected with CMV as far back as January 2014, which was well before the IUI procedure resulting in her pregnancy.[33] The plaintiff's expert on causation, Dr. McMeeking, disagrees because the level of IgM antibodies in Ms. Monroe-Lynch's serology report on the day of delivery was significant, and within the generally recognized period of between six to nine

---

[32] "Q Right. I understand that. The only -- the only reason I'm asking, Doctor, is because if hypothetically speaking if Ms. Monroe-Lynch contracted CMV and had the infection, say, in the month of January of some year she could remain IgM positive for six to nine months. Correct?

A That is correct.

Q So she could have been IgM positive in this specific case if she was sick with CMV in January of 2014, she could have still been at the IgM stage when she was inseminated in May of 2014, a little bit less than four months later. Correct?

A It -- it's possible, but, again, we have the data at the time of her delivery. She still has very high IgM levels which would rule out the possibility of an infection the prior year. That just wouldn't be scientifically possible.

Q So you're saying that she could be IgM for nine months but not for eleven or twelve?

A Not at that level. It should be more or less resolved by nine months gone; so I did think about that. I know we haven't talked about it, but the prior year that hospitalization with the respiratory infection, to have that high level of IgM a year later just wouldn't be possible. It -- it would have resolved. There would be extremely borderline positive. It wouldn't be high like the doctors at the hospital are saying. That's just not possible."

Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 16.

[33] Dr. McMeeking has opined, consistent with the generally held view, that IgM antibodies remain detectable for six to nine months after an initial CMV infection. Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 32, ll. 13-19, p. 33, ll. 5-18, p. 37, ll. 12-22; 11/12/2020 p.m. at p. 15, ll. 4-11, p. 16, ll. 18-27 and p. 17, ll. 1-16; 12/11/2020,7 p. 29, ll. 19-23; Tr. of Dr. Schleiss, 12/10/2020 p.m., p. 55, ll. 26-27 and p. 56, ll. 1-12. However, Dr. Schleiss also testified that IgM antibodies can be detected for more than a year after a primary CMV infection. Dr. Schleiss a.m. Session, p. 75. Dr. Schleiss generally conceded this was outside the norm and, significantly, he has been published with another author, stating the generally held view that IgM levels wane after six to nine months. IgM levels thereafter dissipate and IgG antibodies develop in their place as the virus becomes latent and remain for the life of the host.

months of insemination. Based upon this opinion, Ms. Monroe-Lynch may have been infected as early as April, 2014, near the time of insemination on May 11, when the sample from CMV positive donor # 013673 was injected into her uterus during the IUI procedure. Dr. McMeeking concludes that it was extremely unlikely, if not impossible,[34] to maintain an IgM antibody level of 51.5 at the time of birth, if the initial infection occurred in January 2014, several months before the IUI procedure was conducted as posited by the defendants.[35] The court credits Dr.

---

[34] Q Okay; so she presented with things like cough, fever, body aches, had difficulty breathing --
A Right.
Q -- with this presentation in January of 2014. Right?
A That is correct.
Q And she was, actually, discharged from this presentation with a diagnosis of flu-like illness. Correct?
A Correct.
Q So her signs and symptoms at this time, certainly, were consistent with a CMV infection. True?
A It's possible. And, again, except for the IgM antibody a year later makes it impossible.
Q Okay; so -- and I want to pin that down because what you're saying is it is impossible if someone has a CMV infection -- I'm looking for the date here, January 15 of 2014, it is in your opinion impossible for her IgM level to -- for there still to be a high IgM level exactly a year later in January of 2015. Right?
A Maybe impossible is too strong a word, but I would say extremely unlikely.
Q Okay. If you assume that this was CMV in January of 2014 she --
A Right.
Q -- could have zero -- I'm sorry? . . . if this had been CMV in January of 2015 she could have still been IgM in May, four months later. Correct?
A Possibly. Yes.
Q Or she could have zero converted meaning her IgM level went down as her IgG level went up. Correct?
A Yes.
Q Either way she could have transmitted CMV to the fetuses from the CMV infection she had in January. Correct?
A Except my opinion is there's no way she had CMV in January of 2014.
Q But you have no basis for that opinion, do you?
A Oh, yes, I do. The antibody level is far too high a year later with IgM for it to have happened a year prior. It's just not scientifically feasible." Tr. of Dr. McMeeking, 11/12/20 p.m. pp. 44-46.

[35] Q Okay. Regarding the testimony that if Ms. Monroe-Lynch had CMV in January of

McMeeking with the more credible explanation of the timing of Ms. Monroe-Lynch's initial infection, which was at or about the time of the insemination.

Assuming that Ms. Monroe-Lynch experienced her primary infection through community spread, the defendants posit that her high IgM level at the time of birth in January 2015 indicates that she was still producing IgM antibodies and was still capable of shedding virus and infecting others during the pregnancy, including Shay and Joshua. The defendants' causation expert, Dr. Schleiss, therefore opined that Ms. Monroe-Lynch's primary CMV infection occurred sometime in the months before or during her first trimester, and, once the pregnancy advanced to the point the fetuses were susceptible to infection, the virus was transmitted via the placenta while Ms. Monroe-Lynch was IgM positive.

Critical to the plaintiffs' theory of causation, however, is that a CMV infection occurred at the time of conception. This finding would be consistent with the severe nature of the infection contracted by Shay and Joshua. The plaintiffs have submitted an article about the effects of CMV, Ex. 64, that states: "[O]ur results suggest that the potential severity of fetal infection is restricted to maternal infections in the first trimester of pregnancy."[36] Consistent with this theory of severe fetal infection, as occurred here, Dr. Schleiss's opinion is that Shay

---

2014 her IgM would have disappeared by January of 2015, do you agree with that?

A No.

Q And in regards to the statements that her IgM level at 51.5 or even 53.5 that that was an extremely high level, do you agree with that statement?

A No."

Tr. of Dr. Schleiss, a.m. Session, p. 77.

[36] Ex. 64, Bates 1348.

and Joshua were infected between twelve and twenty weeks, beginning near the end of the first trimester.[37]

The defendants suggest this presumed CMV infection in January, or at any time thereafter, was the result of "community spread" of the disease. Consistent with this theory, the defendants contend that throughout the sixteen (16) month period between Ms. Monroe-Lynch's IgG negative blood test by CARS and the subsequent delivery of her twins in January of 2015, she was exposed to many clients and coworkers at the Wheeler Clinic. It is also posited that Ms. Monroe-Lynch had other, possible exposures to CMV. For example, her husband was a high school English teacher at that time and he was, therefore, exposed to possible community spread among students in the public school system. In addition, her adopted son, Isaiah, was attending school at that time and he regularly visited with his two year old half-sister, born to Ms. Monroe-Lynch's previous partner, Natalie.[38] There is no evidence in the record, however, showing that any of these individuals were infected with CMV prior to the delivery of Shay and Joshua.

The court therefore concludes by a preponderance of the evidenced presented, but only as to the timing of the CMV infection, that Ms. Monroe-Lynch contracted CMV nearer the time of the June 8 and 9, 2014 ED visits, thereby strongly associating the plaintiffs' CMV infection with the May 11, 2014 IUI procedure at CARS.[39] In particular, Ms. Monroe-Lynch's IgM level of

---

[37] Defendants' Brief p. 32, Entry #327.

[38] Notably, Natalie conceived Isaiah through a TDI procedure, successfully performed at CARS years earlier.

[39] One medical record suggests that the plaintiffs' CMV was contracted in the third trimester of Jean-Marie's pregnancy. Exhibit 40. This opinion expressed by Dr. Park, however, appears to be preliminary to the autopsy results and contains no expressed, factual foundation. Moreover, it is contradicted by the evidence presented of severe infection at the time of delivery, which occurred at 37 and $^{2}/_{7}$ weeks and, in particular, the severe medical consequences to Joshua, and especially to Shay who died of the disease, as there is a general consensus that CMV causes the most profound effects when contracted by the mother early in the first trimester of pregnancy, as

51.5 at the time of delivery on January 13, 2015, is significant evidence supporting the finding that there was an active, initial CMV infection within the gestational period, but not a full year earlier when she presented with flu-like symptoms at the ED visit in January 2014. As Dr. McMeeking stated, at the time of delivery, "[s]he still has very high IgM levels which would rule out the possibility of an infection the prior year. That just wouldn't be scientifically possible."[40]

In addition, severe birth complications also diminish in relation to the time of the initial infection. "The risk of CMV-related neonatal complications for women infected at least six months before conception appears very low."[41] Given the severity of the neurological and other health consequences of the infection in these twins, this further refines the probability that the infection of the plaintiffs occurred within the first trimester. Under Dr. Schleiss' analysis, an

---

occurred here. Tr. of Dr. Schust, 11/10/2020 at p. 107, ll. 23-27 and p. 108, ll. 1-12; Trial Testimony of Dr. Henry Prince, 11/19/2020,13 p. 11, ll. 16-27; Trial Testimony of Dr. David Park, 11/17/2020, p. 12, ll. 3-27, p. 13, ll. 1-2; Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 28, ll. 21-27 and p. 29, ll. 1-7, p. 37, ll. 23-27 and p. 38, ll. 1-7; 11/12/2020 p.m. at p. 70, ll. 22-27 and p. 71, ll. 1-6; Trial Testimony of Dr. Samuel Parry, 12/02/2020,15 p. 42, ll. 18-22; Tr. of Dr. Schleiss, 12/10/2020 p.m. at p. 58, ll. 14-17; Exhibit 64, Faure-Bardon, et al, Bates 1343; Exhibit 270 (Dr. Turner's file), ACOG Practice Bulletin, Bates 18457.

[40] "Q Right. I understand that. The only -- the only reason I'm asking, Doctor, is because if hypothetically speaking if Ms. Monroe-Lynch contracted CMV and had the infection, say, in the month of January of some year she could remain IgM positive for six to nine months. Correct?

A That is correct.

Q So she could have been IgM positive in this specific case if she was sick with CMV in January of 2014, she could have still been at the IgM stage when she was inseminated in May of 2014, a little bit less than four months later. Correct?

A It -- it's possible, but, again, we have the data at the time of her delivery. She still has very high IgM levels which would rule out the possibility of an infection the prior year. That just wouldn't be scientifically possible.

Q So you're saying that she could be IgM for nine months but not for eleven or twelve?

A Not at that level. It should be more or less resolved by nine months gone; so I did think about that. I know we haven't talked about it, but the prior year that hospitalization with the respiratory infection, to have that high level of IgM a year later just wouldn't be possible. It -- it would have resolved. There would be extremely borderline positive. It wouldn't be high like the doctors at the hospital are saying. That's just not possible."

Tr. of Dr. McMeeking, 11/1/20 p.m. p. 16, ll. 1-17.

[41] (Footnotes omitted.) Exhibit 29, Bates 655.

initial infection in January, resulting in an infection of Shay and Joshua at week twelve of gestation, would be outside this window of serious neo-natal complications resulting from an initial CVM infection.

The court also credits Dr. McMeeking's opinion that adult transmission of CMV is far more likely to involve sexual transmission, including an IUI procedure. Further, there is no substantial evidence in the record that Aaron, Isaiah or anyone else in close physical contact with Ms. Monroe-Lynch, carried IgM or IgG antibodies during the pregnancy. Even if the court were to assume facts not in evidence, that Mr. Lynch was IgM or IgG positive, he produces no semen or seminal fluid as a transsexual male, thereby eliminating one significant medium of intimate, sexual transmission. We are therefore left with two competing theories of the timing of Ms. Monroe-Lynch's infection: either she was infected with CMV during a very narrow window and opportunity for community spread from an unknown source, as posited by the defendant, or as alleged by the plaintiffs, her CMV infection resulted from the IUI procedure, in which donor # 013673 sperm was used to inseminate Ms. Monroe-Lynch directly into her uterus, bypassing any protection her cervix might otherwise provide.[42]

[42] Through intercourse, the cervix filters white blood cells, the dead cells, and prostaglandins out, and only motile sperm get through. Tr. of Dr. Shamonki, 12/03/2020 at p. 49, ll. 25-27 and p. 50, ll. 1-2. In an IUI procedure, the cervix is bypassed and semen is deposited directly into the uterus bypassing the filtering mechanisms of the cervix. Tr. of Dr. McMeeking, 11/12/2020 p.m. at p. 70, ll. 14-21.

B

CMV In Donor Sperm

The infectiousness of sperm samples from IgG positive donors represents a highly contested factual question in the present matter. In seeking to prove causation, the court again notes that the plaintiffs rely upon circumstantial evidence, remembering again that donor sperm samples, such as the one used here, are not tested for the presence of live CMV. Therefore, no direct evidence has been presented in the record that the sample used from donor # 013637 to inseminate Ms. Monroe-Lynch on May 11, 2014, contained an infectious level of CMV. Furthermore, the parties dispute the scientific evidence, showing that infectious CMV may remain in washed sperm samples used in TDI procedures.

It is nonetheless undisputed by all parties and experts in this case, that insemination of a CMV negative patient with CMV positive donor sperm is only within the standard of care if the patient consents, after she is appropriately informed of the risk of congenital CMV.[43] The defendant characterizes this risk, however, to be merely "theoretical" and not a proven risk as a matter of scientific fact. Thus, the scientific proof of causation remains disputed in this matter.

"In a medical malpractice action, expert medical opinion evidence is usually required to show the cause of an injury or disease because the medical effect on the human system of the infliction of injuries is generally not within the sphere of the common knowledge of the lay person. . . . Such expert opinion may be provided through a signed report of a treating physician

[43] E.g. Tr. of Dr. Schust, 11/13/2020, p. 5, ll. 6-14; p. 12, ll. 3-15; Tr. of Dr. Schust, 11/10/2020, p. 44, ll. 18-27, p. 45, ll. 1-3, p. 46, ll. 11-27 and p. 47, ll. 1-9. Tr. of Dr. Benadiva pp. 146-49, 153-55, 157-58.

in lieu of live testimony, as long as the defendant is afforded an opportunity to cross-examine the author of the report." (Citations omitted; internal quotation marks omitted.) *Milliun* v. *New Milford Hospital,* 310 Conn. 711, 725–26, 80 A.3d 887 (2013). "The essential element of causation has two components. The first component, causation in fact, requires us to determine whether the injury would have occurred but for the defendant's conduct. . . . The second component, proximate causation, requires us to determine whether the defendant's conduct is a substantial factor in bringing about the plaintiff's injuries." (Citations omitted.) *Stuart* v. *Freiberg*, 316 Conn. 809, 833, 116 A.3d 1195 (2015). "No matter how negligent a party may have been, if his negligent act bears no relation to the injury, it is not actionable." (Citation omitted.) *Greci* v. *Parks*, 117 Conn. App. 658, 674–75, 980 A.2d 948 (2009); see *Barnes* v. *Connecticut Podiatry Group, P.C.,* 195 Conn. App. 212, 240–41, 224 A.3d 916 (2020).

In analyzing the question of causation in the present matter, it is extremely important to distinguish between ordinary semen and the insemination product sold by sperm banks and ultimately used in TDI procedures. The scientific evidence is clear that ordinary semen is capable of carrying pathogens such as CMV.[44] Further, although it is undisputed that an IgG positive person is capable of shedding CMV into semen and other bodily fluids, shedding is episodic for healthy people and is not necessarily a constant and continuous process. Although IgG positive people shed more often earlier in the progression of their disease, some stop shedding the virus altogether, while others shed when compromised by an inflammatory condition, other than CMV. The defendant's expert conceded, however, that it is possible for a healthy CMV positive person to occasionally shed CMV: "Shedding is rare and episodic . . . *less*

[44] Exhibit 56, Bates 1240; Exhibit 70, Bates 1423; Exhibit 74, Bates 1442.

than five percent of the time."[45] Although viral shedding is highest during an active infection, it decreases and usually ceases until there is a trigger. According to Dr. Schleiss: "the short answer is that, you know, not everyone reactivates; those that do, usually there's a trigger that leads to the reactivation." Id. p. 30. From these facts, the court concludes that it is scientifically accepted that an otherwise healthy IgG positive male, such as donor # 013637,[46] may occasionally shed live CMV into semen and other bodily fluids.[47]

Although it would be speculative to assume that shedding occurs in 5% of semen samples collected for insemination, infra, the court would characterize the possibility of shedding live CMV into semen as neither impossible nor insignificant. For this reason, presumably, semen collected for TDI procedures at sperm banks is subjected to a process to remove pathogens, as occurred here, known as "washing," by using a "density gradient process." The evidence shows that the samples used in all TDI procedures conducted at CARS is subject to a washing procedure between the time of collection and insemination. This is a process by which live spermatozoa are separated from the donor's semen by centrifuge and other additives, eliminating much of the white blood cells, dead cells and other organic materials that are considered more likely to harbor pathogens, including CMV.

---

[45] (Emphasis added.) Dr. Schleiss 12/10/20 AM pp. 28-29.

[46] There was no evidence presented that the IgG positive donor in this case, #013637, had an active infection at the time of collection or that he was anything other than a healthy individual.

[47] The defendant's infectious disease expert, Dr. Schleiss, minimized the amount of infectious virus that is actually shed by IgG positive individuals, but conceded that, although somewhat cluttered with other material, it is in-fact shed into bodily fluids. "[M]ost of the time, you know, we would think of viral shedding as meaning shedding infectious virus that's usually cell associated. But, in fact, there's lots of other stuff there: viral DNA, bits and chunks and pieces of viral DNA that's not infectious." Dr. Schleiss 12/10/20 AM, at p. 33. As the virus replicates itself and is shed, Dr. Schleiss opined that less than 10% of what is shed is an infectious virus particle. Id. at 37-38.

Clinical research demonstrates by polymerase chain reaction (PCR) testing that CMV exists in both seminal fluid and spermatozoa.[48] Although most of the potentially pathogenic material may be removed during the washing process, there was consensus among the experts at trial that some residual white blood cells (leukocytes) and DNA from CMV may remain in the processed donor samples. Dr. McMeeking, as well as the defendant's sperm bank expert, Dr. Shamonki, testified that the residual virus may not be completely removed through either the washing or freezing processes.[49] The defendant's REI expert, Dr. Gutmann, reluctantly concurred that there is no method to ensure that infectious agents, including CMV, will not be introduced via insemination.[50]

Despite basic agreement on these issues of fact, the experts expressed divergent points of view on the questions of whether there could be infectious CMV remaining in a washed donor sample and, if so, the actual methodology of transmission into an egg (oocyte) and ultimately into a fetus. The defense summed-up the attenuated nature of the plaintiffs' scientific claims in the following question, posed to Dr. McMeeking while testifying at trial:

---

[48] Tr. of Dr. Shamonki, 12/03/2020, p. 83, ll. 19-27, p. 96, ll. 7-27 and p. 97, ll. 1-5; Tr. of Dr. McMeeking, 12/11/2020, p. 2, ll. 17-20, p. 3, ll. 14-24, p. 44, ll. 26-27 and p. 45, ll. 1-20; Exhibit 83, Naumenko, et al.

[49] Tr. of Dr. McMeeking, 11/12/2020 a.m., p. 65, ll. 2-4, p. 39, ll. 25-27, p. 40, ll. 1-12, p. 49, ll. 1-6, p. 52, ll. 4-6; Tr. of Dr. Shamonki, 12/03/2020, p. 83, ll. 7-18.

[50] Q Okay. And isn't it true, Doctor, that there's no method to completely ensure that infectious agents will not be transmitted through TDI?

A There is a theoretic risk of infection being transmitted.

Q So isn't it true that there's no method to completely ensure that infectious agents will not be transmitted through TDI?

A There is a theoretical risk that infections can be transmitted, so yes."

Tr. of Dr. Gutmann, p. 74, ll. 3-12.

"Q: Okay; so just to sum it all up so that we're all following, the assumption that we have to make for your opinion to be valid is that the donor was shedding on the day of his donation. He shed enough infectious and viable material, and he shed it into the semen, that that virus that he shed survived the washing process and that once the sperm or inseminated into the uterus the viral -- the infectious virus that was either hanging off of the sperm or embedded in the sperm survived the trip up the fallopian tube survived the barriers that the sperm had to go through to get into the egg and survived in the egg and, in fact, actually, was replicating inside the egg. Is that accurate?

A: Yes."

Dr. McMeeking PM 11/12/20, p. 31.

In support of his conclusion regarding causation, Dr. McMeeking concurred that neither washing nor freezing removes the CMV virus in its entirety from sperm samples used in IUI procedures.[51] He further testified that CMV survives in three places: seminal fluid; attached to the outside of sperm cells; and within sperm itself.[52] Specifically, Dr. McMeeking contends that the CMV virus both attaches to the spermatozoa membrane and infects the interior of the sperm cell – in the head, tail and connecting segments of the cell.[53] The infected spermatozoa then enters and fuses with the egg to create the embryo.[54]

---

[51] Tr. of Dr. McMeeking, 11/12/2020 a.m., p. 65, ll. 2-4.
[52] Tr. of Dr. McMeeking, 11/12/2020 a.m., p. 64, ll. 20-25; 12/11/2020, p. 4, ll. 13-17, p. 51, ll. 17-23.
[53] Tr. of Dr. McMeeking, 11/12/2020 p.m., p. 23, ll. 23-27 and p. 24, ll. 1-2, p. 29, ll. 7-27 and p. 30, ll. 1-4; 11/12/2020 a.m., p. 55, ll. 8-16, p. 63, ll. 25-27 and p. 64, ll. 1-25; Exhibit 83, Naumenko, et al.
[54] Tr. of Dr. McMeeking, 12/11/2020, p. 19, ll. 21-27, p. 20, ll. 1-4.

Although Dr. McMeeking's expert opinion concludes that it was possible for Ms. Monroe-Lynch to have been infected first, followed by the embryos, based upon the severity of injuries to the fetuses, he believes the most scientifically likely mechanism of transmission was that the donor # 013763's spermatozoa infected the embryos, akin to a "Trojan Horse," causing congenital CMV to develop in both fetuses due to infection early in the first trimester.[55] This opinion was bolstered by an article presented to him during his examination by plaintiffs' counsel, in which stained CMV DNA was shown to exist within spermatozoa in a laboratory setting.[56]

The conclusion that infectious CMV may be found in washed donor sperm samples is additionally supported by the guidelines used by REI and MFM specialists, published by the American Society for Reproductive Medicine (ASRM), consisting of leading scientists and physicians in the field of reproductive medicine. At the time of the plaintiff's insemination, the ASRM concluded that "[t]here is no method to ensure completely that infectious agents will not be transmitted by TDI. However, the following guidelines . . . should significantly reduce these risks. . . . Men who test positive for active infection (positive urine or throat culture or paired serum samples demonstrating a fourfold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded. Because CMV is so common, insemination with semen from a CMV-seropositive man (without active infection) is permissible when the female partner is also CMV seropositive. Although the practice is not entirely without risk, because there are many strains of CMV and superinfection is possible, the associated risk of newborn CMV

[55] Tr. of Dr. McMeeking, 12/11/2020, p. 13, ll. 10-27 and p. 14, ll. 1-4, p. 19, ll. 21-27 and p. 20, ll. 1-4.
[56] See Exhibit 83, authored by Naumenko.

infection is approximately 1%, and such infants appear to have no significant illness or other abnormality."[57]

It is no surprise then that the mix of an IgG positive donor with an IgG negative patient, as occurred here, requires informed consent before proceeding with any TDI procedure, and especially one as invasive as an IUI procedure, as performed in the present matter. Therefore, in the ASRM practice guidelines and official publication, *Fertility and Sterility*, the conclusion reached in 2012 was that sperm from a CMV positive donor should only be used in a CMV positive woman, because of the risk that transmission of the virus could otherwise occur.[58] Semen donors are therefore screened for CMV because the virus can be transmitted via IUI, and primary infection during early pregnancy may have serious complications in the fetus and neonate.[59] In fact, all of the REI physicians in this case have testified to the authority of the

---

[57] Ex. 30, Bates 662-63. This ASRM guidance appears to assume an approximate infection level of 1%, even among IgG positive matches, due to possible reinfection by another strain of CMV.
[58] "Sperm washing may reduce the risk of transmission of HSV and CMV when the male partner is infected. However, as CMV is so common, insemination with semen from a CMV-infected man is permissible when the female partner is also CMV seropositive." Exhibit 29, Bates 656.
[59] *ASRM Guidelines*, Exhibit 29; see Exhibit 101. "Semen donors are screened for CMV because the virus can be transmitted via IUI, and primary infection during early pregnancy may have serious complications in the fetus and neonate. CMV is the most significant cause of congenital viral infection in the United States. Generalized infection can result in neonatal death or long-term complications such as mental retardation, hearing loss, and blindness. These risks are almost entirely limited to women who were unexposed to CMV prior to pregnancy and contract a primary infection during pregnancy. However, two-thirds of the infants born to women with primary CMV infection during pregnancy do not become infected and only 10% to 15% of the remaining third exhibit symptoms at the time of birth. The risk of CMV-related neonatal complications for women infected at least six months before conception appears very low. Because CMV is so common, insemination with semen from a CMV-infected man is permissible when the female partner is also CMV seropositive. Although the practice is not entirely without risk, because there are many strains of CMV and superinfection is possible, the associated risk of newborn CMV infection is approximately 1%, and such infants appear to have no significant illness or other abnormality (51). In cases of known-donor directed insemination, when the donor is CMV infected and the partner is uninfected, sperm wash may reduce the risk of transmission of CMV to the partner." (Footnotes omitted.) Exhibit 29, Bates 655.

ASRM in the field, including the defense expert, Dr. Gutmann, who serves as a reviewer for some articles published in *Fertility and Sterility*, the ASRM journal.

Further scientific studies are cited by the plaintiffs in support the plaintiffs' assertion that washed sperm samples are capable of carrying infectious CMV. For example, in *Fertility and Sterility*, a study concluded that "[h]uman cytomegalovirus DNA could be detected in one of the positive samples after sperm washing and after centrifugation through a three-layer Perco11 gradient . . . that will be used for IVF or IUI. The persistence of virus after centrifugation through a three-layer Percoll gradient can be related to the persistence of leukocytes, which constitute a known reservoir for human cytomegalovirus."[60]

The question of whether the presence of CMV in washed semen is capable of carrying live, infectious virus, however, remains a central scientific dispute between the parties, in addition to and separate from the question of scientific causation, addressed by other experts. Dr. Jamie Shamonki was called to testify about the methodologies used in producing the samples used in IUI procedures, inter alia, including the one produced by donor # 013673 for use in the present matter. She is a pathologist and the Medical Director of California Cryobank, where the plaintiff purchased sperm from donor # 013673. She explained at trial her opinion that there is no "meaningful risk" or "reasonable threat" of CMV infection from residual CMV in a donor's sample and that donor # 13673 had been through the required FDA serial screening and testing and the sample sold to the plaintiff had been washed.

Dr. Shamonki's opinion was supported by the defendant's infectious disease expert, Dr. Schleiss, who countered the opinion rendered by Dr. McMeeking. He concluded that the

[60] Exhibit 74, Bates 1446.

Naumenko study cited, infra, did not actually find live or intact CMV within any spermatozoa and he could not conclude, thereby, that live virus could escape the washing process intact. Finding the DNA of altered and stained CMV in a lab dish, he concluded, is not the same as finding live CMV "in the wild" outside of a lab dish and observing it burrowing into and reproducing within spermatozoa.[61]

Dr. Schleiss' opinion is that the stain used in the laboratory setting, as described in Naumenko article presented to Dr. McMeeking, would have found any piece of CMV DNA, infectious or not, and stick to and get inside the cell. Dr. Schleiss further noted that the research cited did not report observing a live, intact and infectious virus attached to sperm, a live virus replicating inside sperm, or even live CMV grown in a sperm in culture medium.[62] Dr. Schleiss also concluded that an egg or oocyte cannot be infected by CMV and, in as much as sperm joins with an egg to create an embryo, without CMV attached or inside the spermatozoa, Dr. McMeeking's primary theory of infection fails as a matter of provable, scientific fact.[63] He does concede that a mother, if infected with CMV, may transmit the virus to her fetus within the first

---

[61] "And then they did a couple of experiments where they took the semen from CMV positive and CMV negative gentlemen and did what's called immuno-fluorescence. What's that? So that -- all that is is it's a probe of a sample using an antibody. And the antibody is conjugated or linked somehow to a fluorescent probe, so when we look at it under the fluorescent microscope we can see signal. So it looks at interactions between antibodies and, in this case, a viral protein called PP65. That was the name of the protein they looked at. And then lastly they took some semen and they spiked it; you know, they threw in a bunch of laboratory adapted virus, a virus known as AD169, that's just the name of the virus, and then they did the same experiment; they did immunofluorescence with this monoclonal antibody to ask if they saw any signal.
Q What's the significance of them using AD169 to spike the samples, if any?
A I think it's important actually. AD169 is not a, you know, what we would call a wild type strain of cytomegalovirus. It's a laboratory passaged version of the virus that can no longer infect people."
Tr. Dr. Schleiss AM, pp. 46.

[62] Tr. Dr. Schleiss AM, pp. 49-53.

[63] Dr. Schleiss PM, Part 1, pp. 57-58; Dr. Schleiss AM, pp. 21, 59-61.

trimester by sharing blood through the placenta, without concluding or suggesting that it occurred in the present matter.[64]

C

Discussion

Based upon the expert testimony proffered, the court finds there is conflicting evidence presented of the scientific basis for concluding that washed sperm samples can be infected with CMV and, specifically, that spermatozoa can carry live, infectious virus. "Conflicting expert testimony does not necessarily equate to insufficient evidence. . . . Rather, [w]here expert testimony conflicts, it becomes the function of the trier of fact to determine credibility and, in doing so, it could believe all, some or none of the testimony of either expert." (Citations omitted; internal quotation marks omitted.) *Procaccini* v. *Lawrence & Memorial Hospital, Inc.*, 175 Conn. App. 692, 721, 168 A.3d 538, cert. denied, 327 Conn. 960, 172 A.3d 801 (2017).

The defendant asserts, moreover, that for scientific evidence to be accepted in a medical malpractice case, it must be reliable. Although evidence of infectious, residual CMV in washed

---

[64] "Q Okay. Is there a point, or I guess better, at what point, if any, does a fertilized egg become susceptible to being infected with a virus like CMV?

A Well, you need a fetus and you need a placenta and you need a maternal and fetal blood circulation. And if you look at fetal development, you don't really begin to see vascularization and -- that is to say, you don't see blood vessels form that communicate with the maternal compartment until, you know, about eight/nine/ten weeks. And at that point in time it is possible, and indeed it does happen, that CMV can cross over from the maternal circulation into the fetal circulation through the placenta. I mean, we know that maternal and fetal circulations are intimately shared; you know, that's how the fetus, the baby, gets oxygen, sugar, and amino acids and other stuff that allow it to grow and develop. But the pathogenesis, that is to say the mechanism by which CMV infects the fetus, requires blood and a placenta. And so that's the process where we see fetal CMV infection occurring."
Tr. Dr. Schleiss AM, pp. 61-62.

sperm samples was conceded by the defendant to be a "theoretical" risk,[65] it maintains that the plaintiffs' scientific evidence of causation is unproven as a matter of scientific fact and that the methodology used is otherwise unreliable. Since the defendant asserts that the plaintiffs' claim of infection by insemination with washed sperm is *a priori* in the present matter, involving theoretical deduction, it would be improper to use such deductive reasoning to prove an essential fact, critical to the evidentiary foundation of the plaintiffs' case, and therefore it cannot be used to support the plaintiffs' circumstantial claim of causation.

The court is required to examine these competing views of causation pursuant to the protocols established for evaluating the admissibility of scientific evidence. Connecticut follows the United States Supreme Court's decision in *Daubert* v. *Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). See *State* v. *Porter*, 241 Conn. 57, 59, 698 A.2d 739 (1997), *cert. denied sub nom. Porter* v. *Connecticut,* 523 U.S. 1058, 118 S. Ct. 1384, 140 L. Ed. 645 (1998). *Daubert* held that "scientific evidence should be subjected to a flexible test, with differing factors that are applied on a case-by-case basis, to determine the reliability of the scientific evidence. . . . Under *Porter,* the proponent of scientific evidence and any testimony that depends on that evidence bears the burden of demonstrating that the methodology underlying the evidence is reliable and that any testimony purportedly reliant upon that evidence is in fact based on that methodology. . . . ([T]here is a further hurdle to the admissibility of expert testimony when that testimony is based on . . . scientific [evidence]. In those situations, the scientific evidence that forms the basis for the expert's opinion must undergo

[65] Dr. Benadiva, the REI doctor who performed the TDI procedures for Ms. Monroe-Lynch in this case, for example, counsels all TDI patients there is a "theoretical" risk of transmission of CMV from an IgG+ donor and, consistent with the warnings in the CARS TDI Information Packet, he advises patients who are IgG- to choose only IgG- sperm donors. Dr. Benadiva pp. 146-49, 153-55 and 157-58.

a validity assessment to ensure reliability.) . . . To carry this burden, the proponent must provide a sufficient articulation of the methodology underlying the scientific evidence. Without such an articulation, the trial court is entirely ill-equipped to determine if the scientific evidence is reliable upon consideration of the various *Porter* factors. . . .

"The factors a trial court will find helpful in determining whether the underlying theories and techniques of the proffered evidence are scientifically reliable will differ with each particular case. . . . Nevertheless, we have approvingly recognized the following considerations: general acceptance in the relevant scientific community; whether the methodology underlying the scientific evidence has been tested and subjected to peer review; the known or potential rate of error; the prestige and background of the expert witness supporting the evidence; the extent to which the technique at issue relies upon subjective judgments made by the expert rather than on objectively verifiable criteria; whether the expert can present and explain the data and methodology underlying the testimony in a manner that assists the jury in drawing conclusions therefrom; and whether the technique or methodology was developed solely for purposes of litigation. . . ." (Citations omitted; internal quotation marks omitted.) *Klein* v. *Norwalk Hospital,* 299 Conn. 241, 261–62, 9 A.3d 364 (2010).

The divergent views of the scientific evidence evaluated by the experts in this matter centers, in part, on whether PCR testing demonstrates that live CMV can exist in both seminal fluid and spermatozoa after the washing procedure has been conducted in preparation of a TDI sample. Dr. McMeeking testified that PCR testing is the most common scientific method for

testing for the presence of infectious agents in the infectious disease field, and is used as a substitute for culture testing because of its speed and efficiency.[66]

Many of the studies proffered by the plaintiffs, for example, support the generally accepted conclusion that CMV is capable of surviving in semen even after undergoing the freezing process.[67] This conclusion is neither disputed by the parties nor their experts. The evidence also shows that it is possible for CMV to survive the washing process and this proposition is conceded by most of the experts who opined on this question, except for Dr. Schleiss.[68] Most, if not all, of the studies used by the plaintiffs support the conclusion that CMV survives the washing process using PCR testing. In evaluating this evidence, Dr. Schleiss countered that PCR testing alone is not enough to establish intact, infectious virus. Dr. Schleiss testified: "we talk about it a lot, is what does it mean to have a positive DNA signal by PCR. Just because viral DNA is there doesn't mean that it's an infectious virus. In fact, usually low levels of DNA are usually not associated with infections."[69] Dr. Schleiss further explained that

---

[66] Tr. of Dr. McMeeking, 11/12/2020 a.m., p. 20, ll. 18-27; 12/11/2020, p. 7, ll. 12-27, p. 8, p. 9, ll. 1-21.

[67] Exhibit 69, Hammitt et al, *Fertility and Sterility*, Bates 1415; Exhibit 96, Witz, et al, Bates 1637; Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 39, ll. 25-27 and p. 40, ll. 1-12, p. 49, ll. 1-6, p. 52, ll. 4-6; Tr. of Dr. Schleiss, 12/10/2020 p.m. at p. 70, ll. 13-20; Tr. of Dr. Shamonki, 12/03/2020 at p. 83, ll. 7-18.

[68] "Seventy-two ejaculates were available for analysis. Of these, 53 samples were examined before Percoll separation and 47 samples were examined afterward. Twenty-eight samples underwent PCR amplification for cytomegalovirus before and after Percoll separation. DNA of HCMV was found in 18 ejaculates (25%), 11 samples of semen (21%), and 7 samples of Percoll-separated sperm (15%). There were 10 positive samples in 24 seropositive men (42%), 1 positive sample in a patient with unknown serology (14%), and 7 positive samples in 41 seronegative men (17%). There were no cases of positive prepreparation and postpreparation HCMV PCR samples. In contrast, there were two cases in which HCMV DNA was amplified from the semen but not from the Percoll-separated sperm." Exhibit 96, Bates 1639, Witz, *Fertility and Sterility*. Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 65, ll. 2-4; Tr. of Dr. Shamonki, 12/03/2020 at p. 83, ll. 7-12.

[69] Tr. Dr. Schleiss AM, p. 33.

PCR is a chain reaction using DNA extracted from a sample treated with an enzyme called a polymerase, heated and cooled repeatedly so that it amplifies and can be studied. After the PCR process is completed, samples show only parts of the viral DNA, as it appears that rendering the DNA from the sample leaves no live virus.[70] In order to find live virus, many more tests would have to be conducted for a conclusive result.[71]

The sum and substance of Dr. Schleiss' opinion is consistent with the defendant's position that it is only theoretically possible for infectious CMV to exist in a washed IgG positive donor sample, and there is no documented proof that it has ever happened or, importantly, that it actually happened to the plaintiff in this case. Although the burden of proof remains upon the plaintiffs, part of the quandary in evaluating the facts in this case is that there is no evidence showing that donor # 013673's sample was infected at the time of insemination because, consistent with the industry standard, the samples are not tested, despite an admitted, theoretical risk.

Consistent with evaluating scientific evidence pursuant to *Daubert* and *Porter,* the court must focus on the reliability of the methodology used in rendering any scientific opinion. Dr. McMeeking claimed to be intimately familiar with the PCR process and testified that PCR is

---

[70] Id., 34-36. "When you're studying something using PCR is PCR showing us live intact virus cells or parts of cells?

A There's no live virus. And it's not really so much a part of the cell as it is a part of the viral DNA."

Dr. Schleiss, TR 12/10/20 a.m., p. 36, ll. 6-9.

[71] "There's no evidence here -- again, you would need at least four additional kinds of experiments to demonstrate that there's actually infectious virus here. PP65 is a rascally little protein that likes to hang around and, you know, create signal, but there's no evidence here for infectious virus. It's a huge distinction. It's really important." Tr. Dr. Schleiss AM, p. 51 ll. 12-18.

regularly used in the scientific community to diagnose infections and to find evidence of organisms such as CMV, HIV and other viruses in bodily fluids. The defendant counters that Dr. McMeeking qualified his description of the reliability of the PCR methodology by stating it is the "standard way of diagnosing and treating the vast majority of infections before cultures become available."[72] However, Dr. McMeeking reiterated that PCR has been justifiably relied upon in the scientific community for decades.[73]

The defendant's expert, Dr. Schleiss, conceded that the use of PCR has been relied upon by the scientific community and is used "to look for the bits of viral DNA and *then we infer that that, you know, may mean something with respect to infectivity.*"[74] He also conceded that the scientific community uses PCR instead of cultures "for lots of reasons, *mostly economic reasons*, quite frankly . . . ."[75]

Primarily for economic reasons, therefore, the court concludes that PCR methodology is accepted and used widely in the scientific community to test for the presence of pathogens,

---

[72] Rebuttal Tr. 12/11/20, p. 16.

[73] "Well, we've known from science back from the 1970s forward that you can indeed find CMV in semen samples either first on cultures and more recently using a technology where you actually isolate the DNA of the virus without having to actually culture it; it's called a PCR, or preliminary chain reaction, which is used now in many areas of infectious disease to help diagnose infections or find organisms in body fluids. So unless you were to test each sperm sample by PCR testing, you wouldn't be able to tell if that person has CMV in their semen or not."

Q Okay. And does the sperm bank -- do the sperm banks do that, to your knowledge, test each sperm sample by PCR testing?

A To the best of my knowledge, no. What they do from my understanding of the literature is they are required to include in the sperm sample they're sending to a fertility center the serology result; is this donor CMV positive antibody or negative. That's all they're required to do."

Tr. of Dr. McMeeking, 11/12/2020 a.m., p. 20-21.

[74] (Emphasis added.) Tr. Dr. Schleiss, 12/10/20 pp. 33-34.

[75] (Emphasis added.) Id.

including CMV, and that a positive finding infers there was infectious virus in the sample tested. From this evidence and expert testimony, the court concludes that studies based upon PCR were properly included in Dr. McMeeking's analysis of causation, based upon a long established process known as differential diagnosis in which causes of medical conditions are established.[76]

Other *Porter* criteria considered in evaluating the opinions of the expert opinions presented include the court's conclusion that all experts were eminently qualified in their fields. They were all able to present and explain the data and methodology underlying the testimony presented in a manner that assisted the court in drawing conclusions from the evidence, and none of the techniques or methodologies appeared to have been developed solely for purposes of this litigation. See *Klein* v. *Norwalk Hospital,* supra, 299 Conn. 261–62. Although the evidence presented was uniformly subjected to peer review, direct evidence by testing the rate of infection in women receiving sperm from CMV positive donors, washed or otherwise, was uniformly viewed as inappropriate and unimaginably unethical due to the risk of infection and the

---

[76] ". . . Differential diagnosis is the process by which -- and this goes back to the beginning of medicine -- a person will present with symptoms, you have a physical examination, you have laboratory data that's available to you, and you come up with a potential series of diagnoses of what the condition could be. As you get more data, you narrow that down till finally you get a definitive diagnosis and hopefully a therapy that will treat that condition.

Q And this process of differential diagnosis, did you use that process with regards to your opinions in this case?

A I did."

TR Dr. McMeeking, 11/12/21 A.M. p. 23. ll. 17-27.

See *DiLieto* v. *County Obstetrics & Gynecology Group, P.C.*, 297 Conn. 105, 114 n. 13, 998 A.2d 730 (2010), rev'd on other grounds, 310 Conn. 38, 74 A.3d 1212 (2013) ("A differential diagnosis is a method of diagnosis that involves a determination of which of a variety of possible conditions is the probable cause of an individual's symptoms, often by a process of elimination. See, e.g., Stedman's Medical Dictionary (28th Ed. 2006) p. 531."), abrogated by *Fairfield Merrittview Ltd. Partnership* v. *Norwalk,* 320 Conn. 535, 556, 133 A.3d 140 (2016) (*McDonald, J.*, dissenting).

devastating effects of congenital CMV.[77] Given this constraint, the expert opinions proffered on the probability of infection under the facts of this case relied less upon some *Porter* criteria, such as the known or potential rate of error or objectively verifiable criteria from studies actually conducted.[78]

In evaluating the evidence of causation, the court is mindful of the following legal principles, specifically applicable to scientific evidence in medical malpractice cases. "All medical malpractice claims, whether involving acts or inactions of a defendant physician,

---

[77] "Q Okay. Thank you. Doctor, is it possible to quantify the risk posed by inseminating a CMV negative person with sperm from a donor who is CMV positive?
A You mean as far as a percentage, sir?
Q Yeah, or a number, yeah.
A I don't know that data cause no one's going around doing studies where they on purpose infect pregnant women with sperm such as this, so I don't know that anyone knows the answer to that, sir.
Q Okay. And to your knowledge has such a study ever been undertaken to test what the risk is in terms of insemination with sperm from a CMV positive donor?
A Not that I'm aware of and I would add I hope it is never done.
Q And why is that?
A Because the catastrophic potential outcome of a CMV infection in a pregnant woman is hellacious.
Q And so why is that fact relevant to a study?
A Well, maybe in an animal model you might have a way of doing this but certainly never in human beings would you expose somebody on purpose to a potentially dangerous and potentially deadly virus.
Q Would that be a requirement of a study to expose someone on purpose?
A Well, I don't know how else you would know the infectivity rate of a semen from a CMV positive man into a woman who's CMV negative; there's -- I don't see any other way of knowing that, in a human model, at least." Tr. Dr. McMeeking 11/12/20 PM, p. 65-66. "It just -- it would be unethical to do the study." Tr. of Dr. Schleiss, 12/10/21 p. 54.

[78] The defendants hypothesize, without citation, that a scientifically valid and ethical study would be possible: "TDI has been used for decades in millions of cases through physicians, clinics, and home use providing ample data for retrospective studies. Any suggestion that it would be unethical to test Plaintiffs' theory of infection by sperm during insemination is disingenuous. At a minimum, a retrospective observational study could be undertaken, using appropriate case controls for comparison, to evaluate the association (if any) between the use of donor sperm from IgG+ men in CMV naïve women and the outcome of the fertilization." Entry # 328, Defendants' Brief, p. 2.

require that a defendant physician's conduct proximately cause the plaintiff's injuries. The question is whether the conduct of the defendant was a substantial factor in causing the plaintiff's injury. . . . This causal connection must rest upon more than surmise or conjecture. . . . A trier is not concerned with possibilities but with reasonable probabilities. . . . The causal relation between an injury and its later physical effects may be established by the direct opinion of a physician, by his deduction by the process of eliminating causes other than the traumatic agency, or by his opinion based upon a hypothetical question. . . .

"To prevail on a negligence claim, a plaintiff must establish that the defendant's conduct legally caused the injuries. . . . As [our Supreme Court] observed . . . [l]egal cause is a hybrid construct, the result of balancing philosophic, pragmatic and moral approaches to causation. The first component of legal cause is causation in fact. Causation in fact is the purest legal application of . . . legal cause. The test for cause in fact is, simply, would the injury have occurred were it not for the actor's conduct. . . . The second component of legal cause is proximate cause, which [our Supreme Court has] defined as [a]n actual cause that is a substantial factor in the resulting harm . . . . The proximate cause requirement tempers the expansive view of causation [in fact] . . . by the pragmatic . . . shaping [of] rules which are feasible to administer, and yield a workable degree of certainty. . . . [T]he test of proximate cause is whether the defendant's conduct is a substantial factor in bringing about the plaintiff's injuries. . . . The existence of the proximate cause of an injury is determined by looking from the injury to the negligent act complained of for the necessary causal connection. . . .

"In other words, [p]roximate cause [is] defined as an actual cause that is a substantial factor in the resulting harm." *Barnes* v. *Connecticut Podiatry Group, P.C.*, 195 Conn. App. 212, 240–41, 224 A.3d 916 (2020). "[I]t is the plaintiff who bears the burden to prove an unbroken

sequence of events that tied his injuries to the [defendants' conduct]. . . . This causal connection must be based upon more than conjecture and surmise. . . . [T]he issue of causation in a negligence action is a question of fact for the trier . . . ." (Citations omitted.) *Arroyo* v. *University of Connecticut Health Center.*, 175 Conn. App. 493, 515, 167 A.3d 1112, cert. denied, 327 Conn. 973, 174 A.3d 192 (2017). "One of the ways to establish the causal relationship between particular conduct of a defendant and a plaintiff's injury is the expert's deduction, by the process of eliminating causes other than the conduct, that the conduct was the cause of the injury." (Citation omitted.) *Shegog* v. *Zabrecky,* 36 Conn. App. 737, 748, 654 A.2d 771, cert. denied, 232 Conn. 922, 656 A.2d 670 (1995).

The defendant has cited federal authority, infra, to guide the court's analysis of the distinguishable nature of general and specific causation, as it disputes first, whether CMV can be generally transmitted, as alleged, and second, whether CMV was transmitted to the plaintiff in this particular case. The defendant suggests that "[g]eneral causation is whether a substance is capable of causing a particular injury or condition in the general population, while specific causation is whether a substance caused a particular individual's injury." (Citations omitted.) *Beyer* v. *Anchor Insulation Co.*, 238 F. Supp. 3d 270, 280 (D. Conn. 2017) (discussing general and specific causation in a toxic tort case). "General causation is established by demonstrating, often through a review of scientific and medical literature, that exposure to a substance can cause a particular disease (*e.g.*, that smoking cigarettes can cause lung cancer). Specific, or individual, causation, however, is established by demonstrating that a given exposure is the cause of an individual's disease (*e.g.*, that a specific plaintiff's lung cancer was caused by his smoking)." *In re Rezulin Products Liability Litigation*, 369 F. Supp. 2d 398, 402 (S.D.N.Y. 2005) (again, discussing general and specific causation in a toxic tort case).

This nomenclature of causation, however, is not generally used in medical malpractice matters to determine proximate cause in Connecticut.[79] One reference to the term "specific causation" can be found in *Klein* v. *Norwalk Hospital,* 299 Conn. 241, 252, 9 A.3d 364 (2010) ("critical to establishing specific causation is exclusion of other possible causes of symptoms"). In reversing the trial court in *Klein*, the Supreme Court used this term in describing an expert's disclosure of causation for purposes of a differential diagnosis and it does not appear to represent a new approach to evaluating causation in medical malpractice cases.[80] Although specific causation may be an interesting approach in evaluating causation by a product, the cause of action in the present matter has been brought sounding in medical malpractice.

In the present matter, circumstantial evidence based upon scientific evidence is a particularly challenging analysis to appropriately articulate and apply, and for the court to reach the proper conclusion as the trier of fact. In doing so, the court relies upon fundamental principles of proof and evidence, applicable in legal matters. "Unlike Aristotelian and Thomistic

---

[79] This matter is pleaded as a medical malpractice claim; not as a products liability claim, despite the interesting fact that causation involves a biological product that was sold to the plaintiffs.

[80] "Critical to establishing specific causation is exclusion of other possible causes of symptoms. . . . As this court recently acknowledged, differential diagnosis is a method of diagnosis that involves a determination of which of a variety of possible conditions is the probable cause of an individual's symptoms, often by a process of elimination. . . . In the present case, Gevirtz was permitted to testify that, in his expert opinion, the plaintiff's alleged injury can only happen as a result of negligence as a result of deviating from the standard of care. To the extent that this conclusion was the result of Gevirtz' differential diagnosis, it necessarily was based on his consideration and elimination of the other possible causes for the alleged injury, including the theory of causation advanced by the defendant. This court never has articulated a requirement that a disclosure include an exhaustive list of each specific topic or condition to which an expert might testify as the basis for his diagnosis; disclosing a categorical topic such as causation generally is sufficient to indicate that testimony may encompass those issues, both considered and eliminated, necessary to explain conclusions within that category." (Citations omitted; internal quotation marks omitted.) *Klein* v. *Norwalk Hospital*, 299 Conn. 241, 252, 9 A.3d 364 (2010).

logic, law does not demand metaphysical certainty in its proofs. In law, we recognize three principal proofs: beyond a reasonable doubt, which is the very high burden in a criminal case; clear and convincing evidence, required to prove fraud and certain other claims, which equates to a very high probability; and preponderance of the evidence, applied to civil claims generally, which means it is more probable than not. None of these varying proofs require absolute certainty.

"To meet one's burden of proof, evidence is necessary. This evidence comes in two forms, direct and circumstantial. The basic distinction between direct and circumstantial evidence is that in the former instance the witnesses testify directly of their own knowledge as to the main facts to be proved, while in the latter case proof is given of facts and circumstances from which the jury may infer other connected facts which reasonably follow, according to common experience. . . . Proof of a fact by the use of circumstantial evidence usually involves a two-step process. A fact is first established by direct evidence, which is ordinarily eyewitness or other direct testimony. That direct evidence can serve as a basis from which the jury infers another fact. Thus, the direct evidence may operate as circumstantial evidence from which a fact is inferred by the jury. . . . When the necessity to resort to circumstantial evidence arises either from the nature of the inquiry or the failure of direct proof, considerable latitude is allowed in its reception. . . .

"An inference is a factual conclusion that can rationally be drawn from other facts. If fact A rationally supports the conclusion that fact B is also true, then B may be *inferred* from A. The process of drawing inferences based on a rough assessment of probabilities is what makes indirect or circumstantial evidence relevant at trial. If the inference (fact B from fact A) is strong enough, then fact A is relevant to prove fact B. Inferences are by their nature permissive, not

mandatory: although the fact proved rationally supports the conclusion the offering party hopes will be inferred, the factfinder is free to accept or reject the inference." (Citations omitted; emphasis in original; internal quotation marks omitted.) *Curran* v. *Kroll*, 118 Conn. App. 401, 408–10, 984 A.2d 763 (2009), aff'd, 303 Conn. 845, 37 A.3d 700 (2012).

In Connecticut, "[p]roof of a material fact by inference from circumstantial evidence need not be so conclusive as to exclude every other hypothesis. It is sufficient if the evidence produces in the mind of the trier a reasonable belief in the probability of the existence of the material fact. . . . Thus, in determining whether the evidence supports a particular inference, we ask whether that inference is so unreasonable as to be unjustifiable. . . . In other words, an inference need not be compelled by the evidence; rather, the evidence need only be reasonably susceptible of such an inference. Equally well established is our holding that a jury may draw factual inferences on the basis of already inferred facts. (Citation omitted.) *Curran* v. *Kroll*, 303 Conn. 845, 857, 37 A.3d 700 (2012).

For plaintiffs to prevail on the question of causation, they are required to prove that washed donor sperm from an IgG positive donor is capable of containing infectious CMV and, further, it was transmitted in this case by inseminating Ms. Monroe-Lynch with sperm from donor # 013673 on May 11, 2014. It has been clearly established by direct evidence that Ms. Monroe-Lynch was IgG negative in September 2013, and that she, Joshua and Shay contracted CMV in 2014, prior to delivery and birth of Joshua on January 13, 2015. At that time, direct evidence establishes by a preponderance of the evidence that Ms. Monroe-Lynch had an initial CMV infection at or about the time of the IUI procedure on May 11, 2014, that Shay died of a CMV infection and that Joshua was born with congenital CMV. Given the severity of the CMV

infections in Shay and Joshua, it is also more likely than not that they contracted CMV early in the pregnancy, within the first trimester.

The court finds by a preponderance of the evidence presented in the record that a washed sperm sample from a CMV positive donor can be, more likely than not, the actual cause of a CMV infection in a CMV negative patient receiving the donor's sample via an IUI procedure. The pervasive concern of the REI profession through testing and disclosure requirements, although characterized as theoretical, is supported by a scientifically factual foundation regarding causation. The primary scientific debate, at least as reflected in the expert testimony in this matter, is the pathology of fetal infections. There appears to be no doubt in the medical community that fetal infection occurs, in utero. There is little, if any, controversy between the experts that CMV may successfully infect a mother initially, who then infects her fetus by the exchange of blood through the placenta. There is, however, a vociferous debate over whether the virus succeeds in infecting an embryo by attaching itself to a spermatozoa and, by entering an oocyte, establishes an infection in a fetus.

The plaintiffs' primary theory of CMV transmission relies upon an infected spermatozoa, or a "Trojan Horse" theory of infection, but not necessarily to the exclusion of a blood-borne theory of transmission. Through extended examination and cross-examination of Doctors McMeeking and Schleiss, their independent positions over the, so called, "Trojan Horse" theory of infection were each supported in scientific literature admitted into evidence. In support of the plaintiff's primary theory of infection, the plaintiffs introduced a study by Dr. Naumenko, et al, entitled "Detection and quantification of human herpes viruses types 4-6 in sperm samples of patients with fertility disorders and chronic inflammatory urogenital tract diseases." Exhibit 83. This study concluded: "Immunostaining of spermatozoa from infected samples and in vitro-

infected cells detected CMV in sperm heads, tails and connecting pieces and revealed attachment to sperm membrane and intracellular localization." Id., Bates 1502. Using immunostaining, the researchers determined that in both lab-infected and naturally occurring sperm cells with CMV, the virus had been present in the sperm heads, tails and connecting pieces. CMV virus both attaches to the spermatozoa membrane and infects the sperm cell in the head, tail and connecting segments of the cell.[81] Based upon Dr. McMeeking's original theory of CMV transmission, later supported by the Naumenko study, he concludes that an infected spermatozoa enters and then fuses with the egg to create the embryo.[82]

Dr. Schleiss countered that the science of CMV transmission does not support this theory of infection, primarily countering that neither spermatozoa nor oocytes are cells and cannot be infected by CMV, as they have no CMV receptors that would facilitate entry into these reproductive entities. When called upon for independent scientific authority for his conclusion, the court allowed the admission of an article by Dr. Kabanova, entitled "Platelet-derived growth factor-α receptor is the cellular receptor for human cytomegalovirus gHgLgO trimer." When confronted with this basic science, Dr. McMeeking considered the vying theories of transmission to be matters of nomenclature and maintained that the transmission, more likely than not, occurs in this manner, especially in light of the profound effects of CMV infection, generally believed to occur very early in pregnancy.[83]

---

[81] Photos of this study were first introduced for demonstrative purposes, but the article itself was later admitted as a full exhibit. See Naumenko Bates 1502 and 1506; Tr. of Dr. McMeeking, 11/12/2020 p.m. at p. 23, ll. 23-27 and p. 24, ll. 1-2, p. 29, ll. 7-27 and p. 30, ll. 1-4; 11/12/2020 a.m. at p. 55, ll. 8-20, p. 63, ll. 25-27 and p. 64, ll. 1-25.

[82] Tr. Dr. McMeeking, 12/11/2020 at p. 26, ll. 21-27 and p. 27, ll. 1-4.

[83] "A Well, what I was saying is I have not come across the words CMV receptors in my reading of the literature or in my clinical work with CMV. But again, if Dr. Schleiss wants to

Although it is not the defendant's burden, the court finds that any suggestion of "community spread" under the facts of the case is purely speculative and is not based upon any direct or circumstantial evidence proffered. Instead, reliable evidence supports the conclusion that CMV, more likely than not, infects a fetus by either attaching to a sperm donor's spermatozoa or is present in residual leukocytes and seminal fluid, present after washing and introduced during an IUI procedure. By that same evidentiary standard, the court further finds that the sperm sample from donor # 013673, more likely than not, caused the CMV infection in the plaintiffs, by either infecting Ms. Monroe-Lynch first, who transmitted the disease later to Shay and Joshua, or by infecting their oocytes directly, resulting in their subsequent illnesses. It is also more likely than not that the infection occurred in the first trimester, by either of these infectious paths, causing the death of Shay and congenital CMV in Joshua.[84] The court therefore concludes by a preponderance of the evidence presented that donor sample # 013673, introduced

---

call these – what I thought – most people in my line of work call binding proteins. If he says that's a receptor, I'm not going to argue that point.

Q Okay. So he might call it receptor, you might call it a protein. In your testimony you're both saying the same thing.

A I believe we are, yes."

Tr. Dr. McMeeking 12/18/20 a.m. p. 42.

[84] The proximate cause found by the court is the introduction of CMV infected sperm into the plaintiff, via Ms. Monroe-Lynch's uterus. Although Dr. Schleiss clearly challenged Dr. McMeeking's infected spermatozoa theory of transmission, infection by blood through the placenta during the critical, first trimester, was acknowledged by both and not ruled out by Dr. Schleiss, although he reached a different conclusion on the question of whether it occurred in this matter. See *Eghnayem* v. *Boston Scientific Corp.*, 57 F. Supp. 3d 658, 703 (S.D. W. Va. 2014) ("an expert's failure to completely rule out a possible alternative cause of a plaintiff's illness should not necessarily lead to exclusion under *Daubert*"). This is a question of neither sole nor specific cause. It involves the path or mechanism of transmission, centered on when during the first trimester the CMV infection probably occurred, resulting in the manifestation and magnitude of the CMV disease present in the twins at the time of delivery. If the insemination caused the infection, then the plaintiffs have met their burden on the causation claim. The plaintiffs posit that there is no way to prove a "chicken or egg" theory of causation beyond a reasonable doubt. But that is not the burden which the civil justice system places upon the plaintiffs. The court agrees.

by the defendant into Ms. Monroe-Lynch-Lynch's uterus during an IUI procedure on May 11, 2014, was the actual cause of the CMV infection contracted by the plaintiffs.[85]

III

MEDICAL MALPRACTICE

The court will briefly set forth the proper standard for evaluating claims of medical malpractice. "[P]rofessional negligence or malpractice . . . [is] defined as the failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss, or damage to the recipient of those services. . . . Furthermore, malpractice presupposes some improper conduct in the treatment or operative skill [or] . . . the failure to exercise requisite medical skill. . . . From those definitions, we conclude that the relevant considerations in determining whether a claim sounds in medical malpractice are whether (1) the defendants are sued in their capacities as medical professionals, (2) the alleged negligence is of a specialized medical nature that arises out of the medical professional-patient relationship, and (3) the alleged negligence is substantially related to medical diagnosis or treatment and involved the exercise of medical judgment. . . . [T]o prevail in a medical malpractice action, the plaintiff must prove (1) the requisite standard of care for treatment, (2) a deviation from that standard of care, and (3) a causal connection between the deviation and the claimed injury. . . . Generally, expert testimony is required to establish both the standard of care to which the defendant is held and the breach of that standard." (Citation omitted; emphasis

[85] The court will address the second aspect of proximate cause, that CMV was a substantial factor in the resulting harm to the plaintiffs, infra.

omitted.) *Jarmie* v. *Troncale*, 306 Conn. 578, 587–88, 50 A.3d 802 (2012); see *Gold* v. *Greenwich Hospital Assn.*, 262 Conn. 248, 254-55, 811 A.2d 1266 (2002); see also *Doe* v. *Cochran*, 332 Conn. 325, 334–35, 210 A.3d 469 (2019).

IV

INFORMED CONSENT

A

Relationship to Medical Malpractice

A cause of action involving informed consent does not neatly fit into a claim based upon medical malpractice. Informed consent does not, for example, require a jurisdictional letter pursuant to General Statutes 52-190a, showing a deviation from the standard of care and is distinguishable from malpractice because its theoretical genesis is derived from the law of battery. See *Schmeltz* v. *Tracy*, 119 Conn. 492, 177 A. 520 (1935). Further, in evaluating claims of physicians not properly obtaining consent for medical treatment, courts are to apply a distinguishable "lay standard" of materiality. "Indeed, in adopting the lay standard for actions for lack of informed consent in *Logan* v. *Greenwich Hospital Association* . . . [the Supreme Court] rejected the traditional standard, which was one set by the medical profession in terms of customary medical practice in the community. . . . Like other courts and legislatures, the court was concerned about [t]he incongruity of making the medical profession the sole arbiter of what information was necessary for an informed decision to be made by a patient concerning his own physical well-being. . . ." (Citation omitted.) *Shortell* v. *Cavanagh*, 300 Conn. 383, 390–91, 15 A.3d 1042 (2011).

In *Shortell*, the Supreme Court expressly held that a cause of action against a physician predicated on a lack of informed consent is not subject to the written opinion letter requirement of § 52-190a. The court explained that "[u]nlike a medical malpractice claim, a claim for lack of informed consent is determined by a lay standard of materiality, rather than an expert medical standard of care which guides the trier of fact in its determination." Id., 388; see also *Logan* v. *Greenwich Hospital Assn.*, supra, 191 Conn. 293 (adopting lay standard for informed consent claims). Accordingly, "in an informed consent case, the plaintiff is not required to present the testimony of a similar health care provider regarding the standard of care at trial." *Shortell* v. *Cavanagh*, supra, at 389; see *Wood* v. *Rutherford*, 187 Conn. App. 61, 76–77, 201 A.3d 1025 (2019).

The plaintiffs here present the question of informed consent as a hybrid claim, contending that, in the field of reproductive endocrinology, it is malpractice to introduce sperm from an IgG positive donor into an IgG negative woman, except where there is informed consent. The court finds that this hybrid approach is consistent with Connecticut case law. See *Viera* v. *Cohen*, 283 Conn. 412, 453, 927 A.2d 843 (2007) (medical negligence and lack of informed consent may provide complementary causes of action); see also *Downs* v. *Trias*, 306 Conn. 81, 90–91, 49 A.3d 180 (2012) (professional failure to communicate risks may be relevant to an underlying claim of medical negligence). Therefore, the claim presented is within the Claims Commission's authorization to bring this action, sounding in medical malpractice.

B

The Plaintiffs' Claims and Relevant Facts

The plaintiffs allege that the defendant committed malpractice based upon negligent fertility treatment. The first ten counts of the complaint are based upon the claim that the defendant did not inform the plaintiff, Ms. Monroe-Lynch, of the risks associated with infection by CMV in the TDI process and, therefore, did not obtain her properly informed consent.[86]

On July 24, 2013, Ms. Monroe-Lynch scheduled her initial visit to CARS and, consistent with its protocol, CARS mailed the TDI New Patient Information Packet (TDI Packet) to the plaintiffs.[87] The introductory letter described the TDI process and referred to the pre-requisite testing. The TDI Packet included 21 detailed instructions, including the required CMV testing, stated repeatedly that patients should complete all testing before buying sperm, and recommended patients access all information available on selected sperm bank websites.[88] The TDI Packet also included a list of CARS approved sperm banks with their web addresses. The TDI Packet contained a medical history form for the patient to complete, along with the TDI consent form. Although the plaintiffs do not recall ever receiving the TDI Packet, they completed the included medical history form on August 10, 2013, before the initial visit with Dr. Benadiva in early September.[89]

On September 3, 2013, Ms. Monroe-Lynch met with Dr. Claudio Benadiva, M.D. of CARS, who is a Board Certified specialist and Professor of Obstetrics & Gynecology and Reproductive Endocrinology and Infertility at UCONN. Exhibit 4. In a progress note and letter

---

[86] Counts one through four allege this cause of action by each of the four plaintiffs. Counts five and six are alleged under this theory by Aaron for filial consortium as to Joshua, the surviving twin, and Shay who passed away in utero. Counts seven and eight are brought by Jean-Marie under the same theory as five and six, but in her own right. Counts nine and ten are brought by Aaron and Jean-Marie, respectively, for negligent infliction of emotional distress.
[87] Ex. 500, Bates 187.
[88] Ex. 501, Bates 3, ¶¶ 3, 6, 7, 9 10.
[89] Ex. 500, Bates 47-56.

to Ms. Monroe-Lynch's general OB/GYN, Dr. Benadiva demonstrated his understanding of both her medical and very significant mental health histories, along with his understanding that she likely required further evaluation for pelvic inflammatory disease and possible treatment options. Exhibit 11.

Understandably, yet noteworthy is the fact that Dr. Benadiva had no recollection of his meeting with Ms. Monroe-Lynch on September 3, 2014. Although Ms. Monroe-Lynch recalls the meeting, she has no recollection of CMV being discussed during her meeting with Dr. Benadiva or during any other appointment with CARS providers.[90] Further, there is no written record of Dr. Benadiva's discussion of CMV risks in Ms. Monroe-Lynch's medical record, including his letter to her referring physician after their initial meeting.[91] All REI the experts

---

[90] The defendants highlight the fact that CARS was previously known to Ms. Monroe-Lynch. Her adopted son, Isaiah, was conceived through the use of its services by his biological mother, Nadia, who was Ms. Monroe-Lynch's partner from a previous relationship. Language our Supreme Court adopted in *Logan* v. *Greenwich Hospital Assn.*, 191 Conn. 282, 465 A.2d 294 (1983) supports consideration of this claim. "Obviously there is no need to disclose risks that are likely to be known by the average patient or that are in fact known to the patient usually because of a past experience with the procedure in question." *Logan* v. *Greenwich Hospital Assn.*, supra, 292; see *DeGennaro* v. *Tandon*, 89 Conn. App. 183, 188–89, 873 A.2d 191, cert. denied, 274 Conn. 914, 879 A.2d 892 (2005). Although a relevant consideration, there is insufficient evidence in the record to conclude that Ms. Monroe-Lynch was previously aware of the risks associated with CMV. First, she did not undergo the treatment leading to Nadia's pregnancy. Second, both Nadia's and Isaiah's CMV status are unknown, leaving the possibility that Ms. Monroe-Lynch may have only had the opportunity to attend a general information session years earlier. This evidence does not necessarily demonstrate, in the court's view, that Ms. Monroe-Lynch was aware of the risks associated with CMV. There is also ample evidence in the record that she is not a reliable historian of her prior mental health treatment.

[91] Exhibits 11, 22 and 24.

"Q Okay. And will you agree with me, Doctor, that nowhere in that letter that you sent to Ms. Hintz did you document that you had told Jean that she was -- that if she was CMV negative, she had to pick or she was recommended to pick sperm from a CMV negative donor?

A It's -- correct, it's not in that letter."

Tr. Dr. Benadiva, 11/5/20 p. 24.

agree, nonetheless, that the introduction of a CMV positive donor sperm into a CMV negative patient is inconsistent with the standard of care, absent informed consent.[92]

Therefore, Dr. Benadiva testified that he discussed the risks associated with TDI, including infectious diseases such as CMV, consistent with his usual habit and practice over the course of his lengthy career. At the time of Ms. Monroe-Lynch's initial meeting with Dr. Benadiva, however, no blood tests had been performed to determine specific risks to her, such as the risk of CMV infection due to her IgG negative status. It is undisputed that after this initial appointment, no CARS provider ever substantively discussed CMV or its implications with

---

[92] The leading professional organization in reproductive medicine, the American Society for Reproductive Medicine (ASRM), has issued specific guidelines relative to the use of CMV positive donor sperm in CMV negative patients because of the significant risk it poses to mother and child. The ASRM, American Society for Reproductive Medicine, retains a membership of approximately 400 fertility centers, 370 of which are registered with SART (Society for Assisted Reproductive Technology). See Exhibit 290 at internal page 29816, subsection B "The Type and Number of Entities Affected." Complying with ASRM guidelines is required for clinic membership in SART – to which CARS belongs, along with 86% of all reproductive medicine clinics in the country. See Tr. of Dr. Benadiva, 11/05/2020 at p. 106, ll. 5-8 and 12-18; Tr. of Dr. Schust, 11/10/2020 at p. 134, ll. 1-9. In order to obtain and keep SART accreditation, clinics are required to comply with all guidelines and recommendations of the ASRM. Tr. of Dr. Benadiva, 11/05/2020 at p. 106, ll. 12-18; Tr. of Dr. Gutmann, 12/08/2020 at p. 105, ll. 10-13. Dr. Benadiva is a member of the ASRM, as are both plaintiff's expert Dr. Schust and defendant's expert Dr. Gutmann. Beginning in 2008 and continuing to its latest publication on the topic prior to the events at issue (2013), the ASRM has recommended that CMV positive donor sperm be used only for patients who are also CMV positive. The most recent guidelines read: Semen donors are screened for CMV because the virus can be transmitted via IUI [Intrauterine insemination], and primary infection during early pregnancy may have serious complications in the fetus and neonate. CMV is the most significant cause of congenital viral infection in the United States. Generalized infection can result in neonatal death or long-term complications such as mental retardation, hearing loss, and blindness. These risks are almost entirely limited to women who were unexposed to CMV prior to pregnancy and contract a primary infection during pregnancy. Because CMV is so common, insemination with semen from a CMV-infected man is permissible when the female partner is also CMV seropositive. See Recommendations for reducing the risk of viral transmission during fertility treatment with the use of autologous gametes: A Committee Opinion, published in Fertility and Sterility, vol. 99, No. 2, February 2013 by The Practice Committee of the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology. Exhibit 29; see also Exhibit 30 (identical language).

either Ms. Monroe-Lynch or Mr. Lynch.[93] After the subsequent analysis of her bloodwork was completed in September, it was determined that Ms. Monroe-Lynch had never been infected by CMV and was therefore IgG negative.[94]

The defendant contends and it is undisputed that Ms. Monroe-Lynch proceeded to immediately and inappropriately select donors after her meeting with Dr. Benadiva, in disregard of CARS written procedures and recommendations. Prior to her blood test, for example, the Monroe-Lynches purchased childhood photographs of an IgG positive donor, # 12635, from the donor website on September 7, 2013. This occurred prior to their September 19, 2013 meeting with the CARS psychologist, Dr. Jacob, who counseled the Monroe-Lynches regarding TDI and reviewed the "Consent for Therapeutic Donor Insemination With Anonymous Donor Sperm" form, which they both acknowledged was explained to them.

On September 20, 2013, Ms. Monroe-Lynch was advised of her CMV negative blood test results by CARS employee, Glorimar Diaz. On September 23, 2013, Ms. Monroe-Lynch informed CARS of her donor selections, donors ## 13186 and 12895, both of whom were CMV negative, consistent with the advice of CARS and Dr. Benadiva. She then purchased a vial of sperm from donor # 13186 that same day for Dr. Benadiva's approval, despite the fact that she was not finally cleared for donor selection until several days later on September 27, 2013.

Despite these actions in disregard of CARS protocols, the defendant maintains that it is significant that Ms. Monroe-Lynch selected two IgG negative sperm donors after her meeting

---

[93] See Tr. of Dr. Benadiva, 11/05/2020 at pp. 27-28; Trial Testimony of Dr. Mary Casey Jacob, 11/06/2020,20 p. 30, ll. 13-17 ("I didn't discuss CMV per se at all"); Trial Testimony of Bethanne Burdick-Shepard, 11/06/2020,21, p. 58, ll. 4-8.
[94] Exhibit 2.

with Dr. Jacobs, despite her earlier interest in an IgG positive donor. Although Dr. Benadiva subsequently reviewed and approved both donors, the September 23, 2013 purchase of the sample from donor # 13186 occurred before Dr. Benadiva's review and approval.

On October 7, 2013, Ms. Monroe-Lynch underwent an unsuccessful in vitro fertilization (IVF) procedure using sperm from donor # 13186, who was IgG negative. The Monroe-Lynches met again with Dr. Benadiva to discuss her next treatment option on October 31, 2013. On this date, Dr. Benadiva authorized Ms. Monroe-Lynch to use any donor without approval, upon which she and her husband executed another detailed consent form that states "[a]lthough pregnancy may be successfully established, there is still the possibility of miscarriage, ectopic pregnancy, stillbirth and/or congenital abnormalities (birth defects). . . ."

Ms. Monroe-Lynch underwent an IVF procedure on November 25, 2013, which did not result in a viable pregnancy. Between November, 2013 and April, 2014, the Monroe-Lynches tried additional procedures, including a surgery to unblock her fallopian tubes, all in an attempt for a successful insemination. On April 29, 2014, Ms. Monroe-Lynch's purchased a vial from donor # 13673. She was inseminated with this sample during an IUI procedure on May 11, 2014, and thereafter became pregnant with Shay and Joshua. At that time, Ms. Monroe-Lynch signed the CARS "Consent for Artificial Insemination Including Intrauterine Insemination (IUI) And Intracervical Insemination (ICI)," which stated "[g]enetic abnormalities, structural abnormalities, mental retardation and other abnormalities may occur following this treatment . . ."[95]

[95] Ex. 500, Bates 21.

Relevant but not necessarily dispositive of the question of informed consent, the court finds that Ms. Monroe-Lynch was generally informed of the risks associated with TDI and with choosing an IgG positive donor. In this regard, the court concludes that the plaintiffs received a TDI Patient Information Package (PIP), despite their claim to the contrary. Specifically included in the PIP is a warning that "[i]f you have never been exposed to CMV, your test will come back negative, and then, you may only choose a CMV negative donor. . . . *** **Until you receive the results from your physician's nurse, we suggest you only research donors who are CMV negative.**"[96] (Emphasis in original.) The court is also satisfied that Dr. Benadiva generally described the risks of TDI procedures at their initial meeting on September 3, 2013, including the theoretical risks associated with a CMV infection.

The experts who testified at trial agree, and the court concludes, that the generic warning in the PIP sent to the plaintiff parents is insufficient for purposes of finding informed consent. Consistent with Connecticut law,[97] all experts who testified also agree that it is the physician's duty to provide medical risk information to patients, upon which they may appropriately agree to treatment. On the other hand, the experts additionally agree that a specific, written consent form is not required by the standard of care for REI doctors when inseminating an IgG negative patient with sperm from an IgG donor. The experts appear to disagree, however, over the appropriate timing and language used to inform a patient of the risk of contracting a CMV

[96] Exhibit 7 p.3 para. No. 6.

[97] *Sherwood* v. *Danbury Hospital*, 278 Conn. 163, 185–86, 896 A.2d 777 (2006) (it is the treating physician's duty to inform the patient of the risks and benefits of, and alternatives to, a proposed medical procedure and to obtain the patient's informed consent before performing any such procedure).

infection through TDI procedures, especially prior to serology testing done to determine a patient's CMV antibody status.

The plaintiff's REI expert opined, for example, that discussing CMV at an initial meeting with a patient, prior to obtaining her bloodwork results, is insufficient where that patient turns out to be CMV negative and selects CMV positive donor sperm.[98] The defendant's REI expert, Dr. Gutmann, also opined that the risks of CMV infection are best described in common language to be truly understood by patients. For example, she "typically describe[s] it as a yucky disease, that . . . can be a truly horrible neurologic disease."[99] Yet on the other hand, Dr. Gutmann, testified that the counseling provided by CARS complied with the applicable standard of care, in that it occurred only once during Ms. Monroe-Lynch's initial meeting with Dr. Benadiva.[100] She, like Dr. Benadiva, has an initial discussion with the patient about the risks of using IgG positive sperm if the patient is IgG negative, which Dr. Gutmann believes is all that is required by the standard of care.[101] In Dr. Benadiva's description of his usual practice of

---

[98] Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 12-27 and p. 7, ll. 1-20.

[99] Dr. Gutmann went further to describe the nature of a proper presentation of the risks associated with mixing IgG positive donors with IgG negative recipients:

"A I do tell them about the potential outcomes. And I typically describe it as a yucky disease, that it can be a truly horrible neurologic disease for their offspring should it occur.

Q Okay. And why is it you use terms like yucky as opposed to some real long medical definitions and things of that nature? Why do you use that?

A I think everybody understands yucky. I don't think that you need to have a whole lot of education or medical knowledge to recognize that yucky is bad. And so I can certainly go into a lengthy discussion with them about sensorineural hearing loss and all sorts of things, but I think yucky conveys what I need to have them understand pretty well."

Tr. Dr. Gutmann, 12-8-20, p. 26.

"Q And you specifically tell them it's a terrible disease, don't you?

A I likely do; there may be one day when I say terrible and one day when I say horrible. So I don't know that I necessarily use both adjectives at the same time. But I certainly try to convey that it is, as I've said before, yucky." Id. 86.

[100] See Trial Testimony of Dr. Gutmann, p. 39, ll. 5-27 through p. 40, ll. 1-16.

[101] Id., p. 23, ll. 24-27; p. 24, ll. 1-10; p. 36, ll. 11-19 and ll. 20-26.

reviewing the risks of TDI procedures, however, he gave no indication that he used common, descriptive language to effectively communicate the potential consequences of a CMV infection early in pregnancy, such as "yucky" or "horrible."[102]

The Dr. Schust's view of the standard of care for informed consent was slightly different. To begin with, it is his opinion that the standard of care requires a fertility clinic to know which patients are CMV negative and to match those patients with donors who are also CMV negative, absence full consultation and informed consent.[103] This appears to be consistent with the defendant's view of the standard of care, at least with regard to the result that the insemination of a CMV negative patient with CMV positive donor sperm is only within the standard of care if the patient is appropriately counselled regarding the risks of CMV and then gives her informed consent.[104]

---

[102] "A Yes. So I tell them what things they need to look for before they make a decision about their donor. I explain the blood work that we're going to do. One of the tests is for CMV and I tell them if you are CMV negative it means that you were never exposed, that there's a small risk of, you know, theoretical risk of acquiring CMV so we prefer that you select a CMV negative donor if you are CMV negative. And I usually tell them there are less donors that are CMV negative but it's, you know, worth to look for those. I tell them also, you know, we're going to look at your family history, there may be some things to look for there. I tell them about the blood type may or may not be important for you to match the blood type. And I offer them genetic testing for cystic fibrosis; some want to do it, some decline. So those are the four things that -- oh, and I tell them don't select a donor until you met with Dr. Jacob because she's -- after the informed consent. So she's going to just ask you know how you choose a donor, is it what they look like, their eye color or their skin color or their education. And once you met with Dr. Jacob and you have all this results, then you can make your final selection. And going back to the informed consent, that was just consent that we have for patients -- if we know that they were using a CMV positive donor and unfortunately in this case we were never told. . . ."
Tr. Dr. Benadiva, 11/5/20 p. 155.

[103] Tr. of Dr. Schust, 11/10/2020 at p. 126, ll. 4-11; 11/13/2020 at p. 13, ll. 16-23 and p. 20, ll. 17-24.

[104] Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 6-12; p. 13, ll. 7-15; 11/10/2020 at p. 120, ll. 22-27, p. 121, ll. 1-2, p. 122, ll. 11-27 and p. 123, ll. 1-9.

The experts' opinions of the REI standard of care then diverge substantially. Dr. Schust cautioned that discussing CMV only at an initial meeting, prior to obtaining bloodwork, is insufficient for a patient to be properly informed and knowingly consent to TDI in instances where a CMV negative patient selects CMV positive donor sperm.[105] His opinion is that the standard of care requires full consultation in such instances, including counseling the patient of the risks of doing so which must be recorded in the patient's medical record.[106]

Both Dr. Schust and Dr. Gutmann nonetheless agree that any counseling with a CMV negative patient regarding the risks of CMV transmission must include a discussion of the devastating neurological and cognitive outcomes associated with congenital CMV infection. For example, when questioned whether "[y]ou specifically tell them that it can lead to horrible neurologic disease, don't you?" Dr. Gutmann answered: "I do, yes."[107] Significantly, Dr. Gutmann testified that not providing this information to the patient is a breach of the standard of care.[108] During his initial meeting with Ms. Monroe-Lynch, Dr. Benadiva does not describe the

---

[105] Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 12-27 and p. 7, ll. 1-20.
[106] Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 12-27 and p. 7, ll. 1-20.
[107] Tr. Dr. Gutmann, 12/08/2020 at p. 85. See Tr. of Dr. Schust, 11/13/2020 at p. 5, ll. 12-27, p. 6, ll. 12-27 and p. 7, ll. 1-20; Tr. of Dr. Gutmann, 12/08/2020 at p. 85, ll. 24-26; p. 89, ll. 2-6; p. 90, ll. 8-12.
[108] "Q Okay. But I am not asking you if you think it is important. What I'm asking you is would that be a breach of the standard of care if the REI physician inseminated a CMV negative woman with sperm from a CMV positive donor without first fully informing that patient of the risks of CMV, would that be a breach of the standard of care if the physician did that? It's a yes or no question.
A Again, I cannot answer that question fully yes or no. It is important for the patient to understand that they are at risk for developing CMV and that they don't want to develop CMV. And so in that regard the answer to your question is the patient should be, must be, and in the absence of providing information to the patient with respect to the potential for transmission would represent a breach.
Q The absence of providing that information would represent a breach. That's what you're saying?
A The absence of counseling the patient with respect to the potential risk of choosing a CMV positive donor would represent a breach."

terrible consequences of a CMV infection, at least in describing his own, usual practice, nor did he make a record of the nature of the information he conveyed.[109]

The experts diverge further over the question of whether informed consent is required after the initial consultation with an REI physician. Dr. Schust concluded that each patient ought to have been informed and have consented to each TDI procedure "[b]ecause each donor choice is a new risk . . . ."[110] Contrary to Dr. Schust's view of an REI Doctor's standard of care, it appears that Dr. Benadiva discontinued his review of Ms. Monroe-Lynch's donor choices after the second insemination, leaving her to her own selections thereafter, including her final insemination on May 11, 2021, resulting in pregnancy.

Importantly, Dr. Schust's view of the standard of care is more consistent with the policies and practices of CARS, when compared with Dr. Gutmann's simpler requirements of only conveying the risks of TDI procedures during initial meetings with a patients. Generally at the time of Ms. Monroe-Lynch's treatment at CARS, it prohibited the matching of CMV negative

---

Tr. of Dr. Gutmann, 12/08/2020 at p. 89-90.

[109] Dr. Schust opined that the standard of care requires that a patient looking to use sperm from a CMV positive donor, including counseling the patient of the risks of doing so, must be recorded in the patient's medical record. Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 12-27 and p. 7, ll. 1-20.

[110] "Q Okay. Does the standard of care require that a fertility clinic review donor choices of a CMV negative patient to ensure that the patient is not selecting a donor choice that may be harmful to the patient?

A I think it does, yes.

Q Okay. And does the standard of care require the fertility clinic to give that same degree of attention and oversight to the patient's second, third, fourth and fifth donor choice as they do to its first?

A Yes.

Q And why is that?

A Because each donor choice is a new risk; I mean, a risk of not just CMV but a risk of HIV or Hepatitis or, you know, any other thing that -- any genetic illness that came up that -- or multifactorial illness that might be transmitted from -- through reproducing. So it's a new, you know, it's a new risk. It's a new procedure, basically."

Tr. Dr. Schust 11/13/20 pp. 10-11.

recipients with sperm from CMV positive donors,[111] and it had two sets of procedures addressing the TDI process and CMV cross-matching.[112] They were CARS Procedures # 2005-020 (Exhibit 9) and #2013-020 (Exhibit 10) and were applicable to all CARS employees during Ms. Monroe-Lynch's fertility treatment, one at the beginning and the other thereafter. [113] After bloodwork results were received, for example, the TDI coordinator was required to discuss the patient's CMV status and their "resulting options in choosing donors,"[114] followed by documentation of the call and the items discussed.[115] The CARS procedures then state that if a CMV negative patient selects sperm from a CMV positive donor, the TDI Coordinator would email a CMV consent form[116] to the patient and refer her to her physician for consultation. Exhibits 9 and 10, Bates 27 and 38. In addition, the 2013 protocol in effect at the time of the successful insemination further stated the TDI coordinator "[a]lerts the physician to the choice of a CMV

---

[111] Tr. of Dr. Jacob, 11/06/2020 at p. 5, ll. 23-27, p. 6, and p. 7 ll. 1-23.
[112] Exhibits 9 and 10; Tr. of Dr. Benadiva, 11/05/2020 at p. 35, ll. 2-16; Exhibit 269, Defendant's Responses to Discovery, Bates 18391 and 18395.
[113] Tr. of Dr. Benadiva, 11/05/2020 at p. 39, ll. 22-27 and p. 40, ll. 1-5; p. 41, ll. 17-27, p. 42, l. 1. These procedures were required for accreditation by the College of American Pathologists, which reviewed the policies and procedures upon inspection.
[114] See CARS Procedure # 2005-020, Exhibit 9, Bates 27; See also #2013-020, Exhibit 10, Bates 38.
[115] Exhibit 10, Bates 38.
[116] Exhibit 9, Bates 27; See also Exhibit 10, Bates 38. Exhibit 1, CARS CMV (-) Recipient's Consent To Use A CMV (+) Sperm Donor, CARS-129. The CMV Consent Form required the patient to indicate understanding that the sperm donor had tested positive for CMV. Exhibit 1; Tr. of Dr. Benadiva, 11/05/2020 at p. 120, ll. 2-27 and p. 121, ll. 1-8. The CMV Consent Form required the patient to indicate that she had read the provided information on CMV included in pages 2 and 3 of the form. Exhibit 1; Tr. of Dr. Benadiva, 11/05/2020 at p. 120, ll. 2-27 and p. 121, ll. 1-8. The CMV Consent Form required that the patient indicate understanding of the risks to herself and her child involved in using sperm from a CMV+ donor. Exhibit 1; Tr. of Dr. Benadiva, 11/05/2020 at p. 120, ll. 2-27 and p. 121, ll. 1-8. The CMV Consent Form required that the patient indicate she had the opportunity to and did discuss possible consequences of using sperm from a CMV+ donor with her physician, and subsequently chose to accept the risks of the procedure. Exhibit 1; Tr. of Dr. Benadiva, 11/05/2020 at p. 120, ll. 2-27 and p. 121, ll. 1-8.

positive donor." In addition, the CMV Consent Form specifically required the signature of both patient and physician after a designated consultation to discuss the risks of the procedure.[117]

In light of these written procedures, the record reveals no signed CMV Consent Form. Although a written consent is not required by law or the REI standard of care, there is no record revealing that Ms. Monroe-Lynch was counseled in the manner described in these policies and procedures regarding the risks of insemination with CMV by sperm from a positive donor, either after her initial meeting with Dr. Benadiva or at the time of her selection and insemination.[118]

Tellingly, Dr. Benadiva appeared to adopt this view of the requirement that specific consent be obtained prior to insemination with sperm from a CMV positive donor. He testified that ". . . going back to the informed consent, that was just consent that we have for patients -- if we know that they were using a CMV positive donor and unfortunately in this case we were never told. . . ."[119] Although it is clear that the plaintiffs ordered the sample from donor # 13673 on their own on April 29, 2014, Dr. Benadiva was no longer reviewing their selections.

The fact of the matter is that, pursuant to the mandates of the FDA, fertility clinics receive notice of a donor's CMV status with each sperm shipment.[120] In the present matter, contrary to the statement of Dr. Benadiva, CARS was informed of the CMV positive status of the donor #13673. It was stated on a "Summary of Records" sent with the vials of sperm to CARS by California Cryobank, in accordance with FDA regulations.[121] Even if the defendant reviewed

---

[117] Exhibits 1, 9 and 10; Tr. of Dr. Benadiva, 11/05/2020 at p. 71, ll. 14-23.
[118] Exhibit 24; Tr. of Dr. Benadiva, 11/05/2020 at p. 72, ll. 5-9, p. 128, ll. 17-20, and p. 166, ll. 1-5.
[119] Tr. Dr. Benadiva, 11/5/20 p.155.
[120] California Cryobank Donor 013673 Summary of Records, Exhibit 17; See Exhibit 554; also see Exhibit 290, Comment 60 & Response, internal pp. 29809-29810.
[121] Exhibit 17, Bates 64; Tr. of Ms. Burdick-Shepard, 11/06/2020 at p. 84, ll. 5-17, p. 148, ll. 1-6.

this summary of records to cross-check the donor's CMV status against Ms. Monroe-Lynch, she was not made aware of the specific risk associated with proceeding with the IUI procedure on May 11, 2014, using the sample from donor # 13673.

Both Dr. Schust and the defendant's standard of care expert, Dr. Gutmann, personally review the CMV status of the donor prior to conducting insemination procedures.[122] Based upon this, Dr. Schust goes further to opine that REI physicians have a duty to compare the CMV statuses of patient-recipients and their donors.[123] CARS diverged from this view of the standard of care and, in contrast, does not review the Summary of Records for the donor's CMV status at the time of insemination.[124] Glorimar Diaz testified that CARS does not review the Summary of Records or the CMV status of either the patient or the donor prior to inseminating the patient.[125] In addition, though the laboratory receives the Summary of Records indicating the donor's CMV status with each vial shipment, and maintains a copy of the recipient history screening form with the patient's CMV status, nobody within the laboratory appears to be charged with cross-checking the CMV status related to a TDI procedure.[126]

---

[122] Tr. of Dr. Schust, 11/10/2020 at p. 96, ll. 2-10, p. 136, ll. 6-16; 11/13/20 at p. 67, ll. 17-22.

"Q Okay. Doctor, in your practice you're always aware of the CMV status of the donor whose sperm will be used in an insemination. Correct?

A At some point in time, yes.

Q Okay. And that's because the information about that donor's CMV status, whether they're IgG positive or negative, that's sent to your clinic on a summary of records form that comes from the sperm bank in accordance with FDA regulations. Correct?

A Correct."

Tr. of Dr. Gutmann, 12/08/20 at p. 90, ll. 13-22.

[123] Tr. of Dr. Schust, 11/10/2020 at p. 134, ll. 22-27, p. 135, l. 27 and p. 136, ll. 1-23.

[124] Tr. of Dr. Benadiva, 11/05/20 at p. 175, ll. 3-15; Tr. of Ms. Diaz, 11/13/20.

[125] Tr. of Ms. Diaz, 11/13/20 at p. 43, l. 27, p. 44, ll. 1-6, pp. 46-47, p. 48, ll. 1-4.

[126] Tr. of Ms. Burdick-Shepard, 11/06/20 at pp. 66-7, p. 77, ll. 23-27 and p. 78, ll. 1-9.

C

Discussion

"Our standard of disclosure for informed consent in this state is an objective standard that does not vary from patient to patient based on what the patient asks or what the patient would do with the information if it were disclosed. As this court stated in Logan, the lay standard of informed consent requires a physician to provide the patient with that information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy. . . . In adopting the objective lay standard, this court recognized that rather than impose on the physician an obligation to disclose at his peril whatever the particular patient might deem material to his choice, most courts have attempted to frame a less subjective measure of the physician's duty. . . .

"We repeatedly have set forth the four elements that must be addressed in the physician's disclosure to the patient in order to obtain valid informed consent. [I]nformed consent involves four specific factors: (1) the nature of the procedure; (2) the risks and hazards of the procedure; (3) the alternatives to the procedure; and (4) the anticipated benefits of the procedure. . . . We have noted that the cases on informed consent require something less than a full disclosure of all information which may have some bearing, however remote, upon the patient's decision." (Citations omitted; emphasis omitted; internal quotation marks omitted.) *Duffy* v. *Flagg,* 279 Conn. 682, 692–93, 905 A.2d 15 (2006).

The court finds, first, that the nature of the IUI procedure performed by CARS to be profound, in that it involves the creation of human life. Second, although the risk of exposure to CMV from a washed sperm sample from an IgG positive donor may be remote, it is a recognized

risk, specifically guarded against in the field of REI. If initially exposed to CMV early in a pregnancy, the resulting contraction of congenital CMV has been described as horrible and may result in life-long and debilitating physical and neurological conditions. Third, clearly there are alternatives to choosing a CMV positive donor, although statistically there are fewer CMV negative donors, given the prevalence of the virus in adults. Finally, the benefits of the procedure are extraordinarily important, allowing couples to engage in family planning, where pregnancy and biological parenting might not otherwise occur.

The court therefore agrees with the plaintiffs' expert, Dr. Schust, that insemination of a CMV negative patient with CMV positive donor sperm is only within the standard of care if the patient is appropriately counselled as to the risks of congenital CMV and gives her full, informed consent.[127] The court further concludes that the defendant's expert agrees with this proposition, generally, except as to timing and context. Specifically, the court finds by the lay standard of materiality, that a reasonable IgG negative patient would have found the risk of contracting CMV during a TDI procedure using sperm from an IgG positive donor to be material in making an informed decision of whether or not to embark upon such a course of therapy.

The court finds that informed consent did not occur in an understandable and meaning full manner in the present matter. In addition, the court concurs with Dr. Schust, that a TDI patient ought to be separately informed of risks associated with a TDI procedure, if it is substantially and materially different from a previous procedures for which consent has been knowingly granted "[b]ecause each donor choice is a new risk . . . ."[128] This standard of care is

---

[127] Tr. of Dr. Schust, 11/13/2020 at p. 6, ll. 6-12; p. 13, ll. 7-15; 11/10/2020 at p. 120, ll. 22-27, p. 121, ll. 1-2, p. 122, ll. 11-27 and p. 123, ll. 1-9.
[128] Tr. Dr. Schust 11/13/20 pp. 10-11.

notably consistent with the policies and procedures of CARS in instances where an IgG negative patent is inseminated with sperm from an IgG positive donor.

In making this finding, the court finds appellate support in *Wood* v. *Rutherford*, 187 Conn. App. 61, 87, 201 A.3d 1025 (2019),[129] in which the Appellate Court concluded that "when a substantial and material change in circumstances occurs during the course of medical treatment, a duty may arise on the part of the physician to secure the consent of the patient before proceeding further." The standard of care for REI physicians proscribes the introduction sperm from an IgG positive donor, absent counselling regarding the specific risk of contracting CMV and consent.[130] Therefore, Ms. Monroe-Lynch's insemination with sperm from an IgG positive donor for the first time on May 11, 2014, gives rise to a substantial and material change in the nature of the IUI procedure that occurred, for which Ms. Monroe Lynch has otherwise granted consent.

The court is mindful of the admonition of the court in *Rutherford* that the duty of informed consent is not absolute and ought to be flexible, depending upon the circumstances

---

[129] The facts in *Rutherford* are somewhat distinguishable from the present matter, but only in the immediacy of the intrusion and resulting harm, without consent. The plaintiff in *Rutherford* had knowingly consented to a laser ablation of her vulva, as well as a postoperative examination. The court found there was a substantial and material change in circumstances when the defendant discovered a labial agglutination which was then separated in a course of treatment imposed without the patient's informed consent. *Wood* v. *Rutherford*, supra, 187 Conn. App. 86–87. Although the facts in *Rutherford* involve an immediate and dramatic intrusion without consent, the facts before this court also involve an intrusion into a reproductive organ with the potential for very serious consequences, without being informed of the risk associated with the procedure.

[130] The plaintiffs had considered an IgG positive donor before their first selections were made in September 2013. Until the sample from donor # 13673 was shipped to CARS on April 29, 2014, for insemination nearly two weeks later on May 11, 2014, samples used for Ms. Monroe-Lynch's insemination procedures appear, from the record and the defendant's brief, to have been from IgG negative donors.

faced by a physician. "[C]ircumstances in which substantial changes arise do not always lend themselves to such a dialogue between patient and physician. For that reason, a physician's duty to secure informed consent is not an absolute one, but rather is contingent on the particular context in which it arises. . . . These include: (1) Situations in which complete and candid disclosure might have a detrimental effect on the physical or psychological well-being of the patient; (2) Situations in which a patient is incapable of giving consent by reason of mental disability or infancy; (3) Situations in which an emergency makes it impractical to obtain consent; (4) Situations in which the risk is either known to the patient or is so obvious as to justify a presumption on the part of the physician that the patient has knowledge of the risk; (5) Situations in which the procedure itself is simple and the danger remote and commonly appreciated to be remote; (6) Situations in which the physician does not know of an otherwise material risk and should not have been aware of it in the exercise of ordinary care." (Citations omitted.) *Wood* v. *Rutherford,* supra, 187 Conn. App. 90–92.

Ms. Monroe-Lynch's elective IUI procedure on May 11, 2014, was planned and scheduled in advance with CARS. Ms. Monroe-Lynch ordered sperm from donor # 13673 directly from California Cryobank on April 29, 2014, as she had been approved to select any donor by Dr. Benadiva on October 31, 2013.[131] The vile of sperm from donor # 13673 was shipped directly to CARS.[132] Pursuant to federal regulations and industry standards, the vial and shipping information labeled the sample to be from an IgG positive donor and CARS was in possession of the vial in advance of the IUI procedure performed on May 11, 2014.[133] Under the circumstances arising in the present matter, the court finds that none of the *Rutherford*

[131] Exhibits 14 & 23.
[132] Exhibit 500, Bates 85.
[133] Exhibit 17, Bates 63-64.

exceptions would apply to obviate the obligation of an REI physician to disclose the risk of introducing sperm from an IgG positive donor into the uterus of an IgG negative patient, absent informed consent.

For these reasons, the court finds that the defendant is liable to the plaintiffs for its failure to adequately inform Ms. and Mr. Monroe-Lynch of the risk associated with selecting a IgG positive donor and thereby obtain her appropriately knowledgeable consent. Had they been properly informed of the risks associated with the selection of an IgG positive donor, they would have withheld their consent and a CMV negative donor would have been substituted.[134]

V

OB / GYN TREATMENT

The second general theory of liability alleged is malpractice based upon negligent prenatal treatment.[135] The plaintiffs allege that the defendant failed to properly detect and respond to abnormal findings during Ms. Monroe-Lynch's ultrasound procedure on October 2, 2014, while in her twenty-second week of pregnancy. The plaintiffs allege that the defendant failed to properly assess and investigate the cause of these findings, including possible CMV infection, before the twin fetuses later became viable and precluded the parents' choice of terminating the pregnancy, which otherwise they would have exercised. The plaintiffs specifically allege negligence on the part of the MFM and OB/GYN teams at UCONN for their

[134] Jean-Marie Monroe-Lynch's 11/03/2020 transcript, p. 70, ll. 1-21, and 11/04/2020 transcript, p. 124, ll. 21-27 and p. 125, ll. 1-6."

[135] This issue of malpractice is evaluated independently of the question of "causation" or the source of the CMV infection.

failure to detect and follow up findings of echogenic bowel, inter alia, on an ultrasound conducted on October 2, 2014 and, further, the failure by both of these departments to communicate and coordinate the medical care of Ms. Monroe-Lynch, Shay and Joshua.

A

Ultrasound of October 2, 2014

After becoming pregnant with Joshua and Shay through an IUI procedure at CARS, Ms. Monroe-Lynch received her prenatal treatment at UCONN. During the pregnancy, she underwent periodic ultrasounds, including one on October 2, 2014, at twenty-two weeks gestation, during which anatomical scans were performed by sonographer Eileen Steinhart and MFM Dr. Gary Turner. During her examination, Ms. Steinhart observed "bright bowel" on both fetuses. She simultaneously noted her initial findings in the ultrasound reporting software in the MFM Department at UCONN and notified Dr. Turner.[136] Dr. Turner testified that he does not recall Ms. Monroe-Lynch or the ultrasound he performed on October 2, 2014, and therefore his testimony was based upon his ultrasound report.[137]

---

[136] The OBserver program contained various categories of ultrasound imaging abnormalities that would appear on the ultrasound machine's screen however "bright bowel" was not one of the available categories or drop-downs. The closest category to "bright bowel" in the OBserver program was "hyperechoic small bowel," which Ms. Steinhart selected during the Lynch's ultrasound to alert the physician to re-evaluate the bowels in both fetuses when the physician performed his/her own ultrasound. See also Trial Testimony of Eileen Steinhart, p. 6, ll. 21-25, pp. 61, p. 72, ll. 17-27; p. 72, ll. 1-6.

[137] The October 2, 2014 ultrasound was performed by Dr. Turner, who also wrote a report of his findings. See Exhibit 36; Trial Testimony of Dr. Garry Turner, 11/17/2020, 30 p. 4, ll. 17-26. At trial, Dr. Turner had no recollection of treating Jean or of the October 2, 2014 ultrasound examination. Tr. of Dr. Turner, 11/17/2020 at p. 5, ll. 7-15.

The diagnostic meaning and significance of the October 2, 2014 ultrasound involves critically important, contested issues of fact. For reasons set forth, infra, the defendant contends that this ultrasound was normal. The plaintiffs disagree and counter that the ultrasound required further testing and evaluation. Furthermore, it is uncontested that Dr. Turner's October 2, 2014 ultrasound report was missing from Ms. Monroe-Lynch's medical record for consideration by her OB/GYN physician, Dr. Park, several weeks later on October 20, 2014, which may otherwise have provided a subsequent opportunity for further testing and evaluation.[138] For reasons more fully set forth below, the court concludes that the October 2, 2014 ultrasound was abnormal, leading to a finding of medical malpractice by the defendant.

The parties do not contest that, in the regular course of a twin pregnancy, periodic ultrasounds are conducted to assess fetal growth and development and the standard of care requires that an anatomy scan be conducted at approximately twenty weeks in order to assess the health of the pregnancy and fetuses. The anatomy scan includes an examination of the abdominal cavity and bowels.[139] During the October 2, 2014 ultrasound, sonographer Eileen Steinhart observed that the fetuses had abnormally small heads and that both appeared to have

---

[138] Though Dr. Turner signed the October 2, 2014 ultrasound report, there is no indication that a copy of the report was ever sent to Ms. Monroe-Lynch's OB/GYN providers, unlike each and the other ultrasounds conducted during her pregnancy. There is no documentation in the prenatal flowsheet, or a review of the report in Dr. Park's notes from October 20, 2014 appointment, several weeks after the ultrasound. See Exhibit 53; Tr. of Dr. Park, 11/17/2020 at p. 22, ll. 1-25, p. 32, ll. 22-25, p. 33, ll. 5-13., the October 2, 2014.

[139] The standard of care for a twin pregnancy is to perform monthly ultrasounds to monitor fetal wellbeing and, around twenty weeks, fetal anatomy, to check growth and development. Tr. of Dr. Atlas, 11/20/2020 at p. 6, ll. 10-16. See Tr. of Dr. Park, 11/17/2020 at p. 7, ll. 14-27; Tr. of Dr. Prince, 11/19/2020 at p. 12, ll. 20-27 and p. 13, ll. 1-21. In an anatomy scan, the fetal abdomen is assessed. Tr. of Dr. Atlas, 11/20/2020 at p. 6, ll. 20-27 and p. 7, l. 1.

prominent, bright bowels. She gave her findings to Dr. Garry Turner, the MFM assigned that day to examine Ms. Monroe-Lynch.[140]

Both the plaintiffs' experts, Dr. Atlas and Dr. Fox, and the defendant's expert, Dr. Parry, testified that echogenic / hyperechoic bowel[141] is diagnosed during an ultrasound by adjusting the "gain" down on the ultrasound machine while visualizing both bowel and bone. A "gain test" is a procedure whereby the physician lowers the "gain" or brightness of the image by using a knob on the ultrasound machine. If the fetal bowel remains as bright as fetal bone on the imaging after the gain is turned down, the diagnosis of echogenic bowel is indicated. Gain testing may only be performed during the live, ultrasound procedure and may not be reconstructed afterward.

The defendant contends that Dr. Turner's report clearly shows that he evaluated both fetuses by ultrasound and ruled out echogenic bowel by performing a "gain test." The results of Dr. Turner's gain test were that the bowel in both fetuses were normal and he recommended that Ms. Monroe-Lynch return for another scan in four to six weeks. It is uncontested that additional ultrasounds were performed on November 3, 2014, December 2, 2014 and December 30, 2014, and no abnormalities were noted.

---

[140] Tr. of Eileen Steinhart, 11/18/2020,29 p. 20, ll. 22-27 and p. 21, ll. 1-6, p. 33, ll. 13-22, p. 50, ll. 21-24, p. 52, ll. 2-27 and p. 53, ll. 1-18.

[141] The terms echogenic bowel and hyperechoic bowel are synonymous. Tr. of Dr. Atlas, 11/20/2020 at p. 7, ll. 24-27 and p. 8, ll. 1; Tr. of Dr. Parry, 12/02/2020 at p. 9, ll. 6-11, p. 36, ll. 26-27 and p. 37, l. 1; Tr. of Dr. Fox, 11/19/2020 at p. 60, ll. 16-18. Although Dr. Turner initially testified at trial that "echogenic" and "hyperechoic" are different terms with different meanings, this is a disparity that is unsupported in clinical practice and with which all other experts, including the defendant's expert Dr. Parry, disagree. See Tr. of Dr. Turner, 11/17/2020 at p. 8, ll. 26-27 and p. 9, ll. 1-10, p. 18, ll. 6-12, p. 68, ll. 19-22.

Contrary to the defendant's conclusion, Dr. Turner's signed[142] ultrasound report reflects abnormal findings in both babies' abdominal cavities. The ultrasound report identified anomalies including "HYPERECHOIC SMALL BOWEL" (emphasis in original) and described: "There is increased echogenicity of the bowel . . . [which] has been associated with meconium peritonitis, Down's Syndrome, cystic fibrosis, intragut blood and CMV infections. It has also been described as a variant of normal. The findings and the differential diagnosis were discussed with the patient."[143] In the report, each of the potential causes of hyperechoic bowel as indicated in the report could be ruled out and were ruled out by Dr. Turner in this case, except for CMV.[144]

The report also specifically indicates that there were abnormalities associated with the abdominal cavity, perhaps due to the finding of hyperechoic bowel, as well as the placenta.[145] In addition and importantly, it was noted that the head circumference of "Twin B" was less than 5%, and was identified in the report as an exception to the otherwise normal anatomical

---

[142] The report "unsigned" by Dr. Turner in 2019. See Exhibit 305, Bates stamp number 18977.

"Q Okay. Doctor, looking on the second half of this screen it says signing history. And then underneath it there's a date, November 13, 2019, and then it says no reason for unsigning was provided by the attending who unsigned the exam. So my question is on November 13, 2019 you unsigned this report. Correct?

A That's what it says.

Q Okay. And you said you did have some recollection of doing this. Correct?

A I don't remember.

Q Okay. And when you unsigned the report you would've had the ability to change the report. Correct?

A I suppose so --

Q Okay.

A -- but I wouldn't have.

Q Excuse me?

A I said I suppose I could have but --

Q Okay.

Tr. Dr. Turner, 11/17/2020, pp. 59-60

[143] Ex. 535 Bates 3; see also Exhibit 36.

[144] Tr. of Dr. Atlas, 11/20/2020 at p. 20, ll. 17-27 and p. 21, ll. 1-2; Tr. of Dr. Turner, 11/17/2020 at p. 32, ll. 15-27 and p. 33, ll. 1-19; Tr. of Dr. Parry, 12/02/2020 at p. 24, ll. 20-21.

[145] Ex. 535 Bates 2; see also Exhibit 36

measurements.[146] The court therefore concludes, contrary to the defendant, that the October 2, 2014 ultrasound report was not entirely "normal."[147] No follow-up was conducted by either the MFM or OB/GYN departments at UCONN.

The genesis of these reported findings of abdominal abnormalities and hyperechoic bowel are not entirely clear from the testimony of Dr. Turner and Ms. Steinhart. They appear to reflect both Ms. Steinhart's initial findings, using OBserver's unedited drop-down menu options, along with Dr. Turner's comments, including a very brief, unformatted statement that "[t]he fetal bowel appeared was prominent in both fetuses, but not as bright as bone."[148] From this statement in the report, Dr. Turner testified that he evaluated the fetal bowel to fetal bone in both fetuses and concluded that neither twin had hyperechoic bowel on that day and determined that no further follow up was required. The meaning and significance of Dr. Turner's findings, and whether the standard of care required further investigation, is disputed by the parties and their experts.

The defendant's expert, Dr. Parry, concluded that Dr. Turner met the standard of care, as he performed a gain study and determined that the bone was brighter than bowel. His opinion appears to rest upon the one very short statement by Dr. Turner in the report, discounting all

---

[146] Ex. 535 Bates 1 & 4; see also Exhibit 36. The finding of a small head, which is different from the clinical diagnosis of microcephaly, is consistent with and concerning for CMV infection. Tr. of Dr. Turner, 11/17/2020 at p. 56, ll. 20-22, p. 84, ll. 14-16; Tr. of Dr. Atlas, 11/20/2020 at p. 26, ll. 11-14; Tr. of Dr. Prince, 11/19/2020 at p. 12, ll. 5-12.

[147] Def. Amended Post Trial Brief, p. 9. Abnormalities of the fetal abdomens were notated on the report in numerous places. Exhibit 36. There are exclamation points identifying abnormalities in the abdominal cavity for both Fetus A and Fetus B, which Dr. Turner testified indicates the bright bowel. Exhibit 36; Tr. of Dr. Atlas, 11/20/2020 at p. 13, ll. 8-11; Tr. of Dr. Turner, 11/17/2020 at p. 56, ll. 3-6. Both fetuses, under anatomy details, also have findings of abnormal abdominal cavities noted. Exhibit 36; Tr. of Dr. Atlas, 11/20/2020 at p. 13, ll. 12-18.

[148] Ex. 535, Bates 3. *See also* Dr. Turner, p. 57, ll. 4-14; p. 79, ll. 7-9, p. 80, ll. 7-12; p. 87, ll. 22-25.

other abnormal findings. The defendant's expert, Dr. Atlas, reached a contrary conclusion. First, he found Dr. Turner's statements inconsistent and confusing in finding that the bone was brighter than bowel amidst other findings of hyperechoic bowel. In evaluating the entire report, however, Dr. Atlas found that the report, taken as a whole, reflected a finding of hyperechoic bowel, which was sufficient to conduct follow-up serology to determine the presence of CMV in Ms. Monroe-Lynch and, if indicated, amniocentesis. This finding was bolstered by the imaging saved from the ultrasound record, showing no indication that the so-called "bright," hyperechoic bowels faded in comparison to bone, despite specific depictions of the fetuses with reduced "gain." Dr. Atlas further concluded that the sheer number of saved images showed concern for the echogenicity of the bowel. Although this finding was sufficient in and of itself, according to Dr. Atlas, his conclusion of abnormal findings was further informed and reinforced by the abnormally small head of Twin B, which was below the fifth percentile. In reviewing the record, the court finds the evidence shows hyperechoic bowels in the fetuses.

In support of this conclusion, both experts agreed that MFM physicians save ultrasound images which are most diagnostically relevant.[149] There is no photographic evidence of a gain study showing bone that is brighter than bowel, however, other than in Dr. Turner's note in the October 2, 2014 ultrasound report. Further, Dr. Atlas opined that, where adjustment of gain shows bowel is not as bright as bone, the MFM would typically save such an image for diagnostic and documentation purposes.[150] The court also credits Dr. Atlas' opinion that where a "normal" bowel is seen, an MFM would not save multiple images of the bowel; conversely, multiple images of the bowel demonstrate a "very big concern" with regard to the findings of the

[149] Tr. Dr. Atlas, 11/20/2020 at p. 28, ll. 12-19; Tr. of Dr. Parry, 12/02/2020 at p. 60, ll. 20-23.
[150] Tr. of Dr. Atlas, 11/20/2020 at p. 77, ll. 26-27 and p. 78, ll. 1-9; Tr. of Dr. Fox, 11/19/2020 at p. 65, ll. 18-26, p. 68, ll. 17-23; Tr. of Dr. Parry, 12/02/2020 at p. 60, ll. 24-27 and p. 61, l. 1.

October 2, 2014 exam.[151] The court therefore agrees with Dr. Atlas that the standard of care in the present matter required a diagnosis of hyperechoic bowel.[152]

In crediting the testimony of Dr. Atlas, the court notes the thoroughness and detail of his analysis of the ultrasound report, in the context of the standard of care. Although the court credits Dr. Turner's veracity and credibility in general, the court takes into account the testimony that Dr. Turner had never previously treated or diagnosed CMV.[153] Further, Dr. Turner testified that hyperechoic bowel as a very common finding on ultrasound.[154]

There is little debate, if any, among the experts that the standard of care requires the following protocol once hyperechoic bowel is diagnosed by an MFM: The patient must be informed of a finding of hyperechoic bowel, and be informed of the potential differential diagnosis of hyperechoic bowel.[155] The standard of care requires that the physician conduct further evaluation, including bloodwork and, if indicated, amniocentesis to identify the potential cause of hyperechoic bowel, including a serology test for CMV.[156] In a patient who is twenty-two weeks pregnant, such as Ms. Monroe-Lynch, bloodwork to test for CMV should be run the same day hyperechoic bowel is observed, if possible.[157] If the mother's serology comes back positive for CMV, the standard of care requires that amniocentesis be offered to confirm congenital CMV infection in the fetuses.[158] Importantly, based upon Ms. Monroe-Lynch's

---

[151] Tr. of Dr. Atlas, 11/20/2020 at p. 10, ll. 24-27, p. 33, l. 27 and p. 34, ll. 1-14.
[152] Tr. of Dr. Atlas, 11/20/2020 at p. 45, ll. 16-19.
[153] Tr. of Dr. Turner, 11/17/2020 at p. 3, ll. 22-27 and p. 4, ll. 1-2; p.78, ll. 21-27; p. 113, ll. 25-27 and p. 114, l.1
[154] Tr. of Dr. Turner, 11/17/2020Id. at p. 79, ll. 10-17.
[155] Tr. of Dr. Atlas, 11/20/2020 at p. 22, ll. 20-27 and p. 23, ll. 1-8.
[156] Tr. of Dr. Atlas, 11/20/2020 at p. 22, ll. 20-27 and p. 23, ll. 1-8 p. 35, ll. 21-23; Tr. of Dr. Turner, 11/17/2020 at p. 10, ll. 19-23.
[157] Tr. of Dr. Atlas, 11/20/2020 at p. 23, ll. 3-8.
[158] Tr. of Dr. Atlas, 11/20/2020 at p. 23, ll. 9-14, p. 35, l. 27 and p. 36, ll. 1-10.

medical record, bloodwork performed shortly after the October 2, 2014 ultrasound would have demonstrated that Ms. Monroe-Lynch was positive for CMV and the twins had contracted congenital CMV.[159] As there are no treatment options for congenital CMV, the standard of care requires that termination be offered to the patient,[160] which Ms. and Mr. Monroe-Lynch testified they would have exercised.

It is undisputed that Dr. Turner did not perform any serology tests, amniocentesis or any other follow up steps, including informing the patient of the finding of hyperechoic bowel and any of its implications or treatment options, all of which were required by the standard of care.[161] For these reasons, the court finds that the defendant is liable to the plaintiffs for medical malpractice.

B

Coordination of Prenatal Care

---

[159] Tr. of Dr. Atlas, 11/20/2020 at p. 43, ll. 12-23; Tr. of Dr. Prince, 11/19/2020 at p. 48, ll. 3-5. Hyperechoic bowel evidences a first-trimester congenital CMV infection. Tr. of Dr. Atlas, 11/20/2020 at p. 24, ll. 20-26; p. 36, ll. 26-27 and p. 37, ll. 1-12.

"A I'd consider that this was an early infection, one which would occur early in pregnancy. And we know that early infection of CMV to the fetus is devastating in general. It is associated with neuro-developmental abnormalities. A majority of these fetuses have chronic expulsion of CMV, what we call chronic CMV. Many of these fetuses have seizure disorder, profound intellectual disabilities, blindness, deafness; just these early ones are just devastating.

Q And would you describe all those things to the 10 patient?

A Yes, and I would use the term devastating as well.

Tr. of Dr. Atlas, 11/20/2020 at p. 37.

[160] Tr. of Dr. Atlas, 11/20/2020 at p. 26, ll. 4-10; Tr. of Dr. Prince, 11/19/2020 at p. 31, ll. 7-12; Tr. of Dr. Parry, 12/02/2020 at p. 38, ll. 19-24.

[161] Tr. of Dr. Atlas, 11/20/2020 at p. 45, ll. 26-27 and p. 46, ll. 1-13; Tr. of Dr. Turner, 11/17/2020 at p. 22, ll. 24-27 and p. 23, l. 1.

Ms. Monroe-Lynch received her prenatal treatment in a "team" approach at UCONN's OB / GYN department, where no one physician was assigned to her. Instead, she was seen by multiple providers during the course of her prenatal care.[162] It is uncontested that Ms. Monroe-Lynch was considered at high-risk, with a twin pregnancy that had been conceived through IUI, and she was overweight with gestational diabetes. She was therefore scheduled for regular ultrasounds to evaluate the health, growth and development of the fetuses.[163]

Consistent with the protocol, Ms. Monroe-Lynch was scheduled for an anatomy ultrasound on September 8, 2014, generally conducted between eighteen and twenty-two weeks of pregnancy to evaluate the development and anatomy of fetuses. That ultrasound that day included the finding of a small head circumference of Fetus B. Because of the positioning of the two babies at the time of the scan, however, the attending MFM physician could not fully evaluate the cranial development of Fetus B. A follow-up ultrasound was scheduled for October 2, 2014, the results of which have been thoroughly addressed, above. See Exhibits 35 and 53.

Dr. Park met with Ms. Monroe-Lynch for an OB/GYN appointment soon afterward on October 20, 2014. As noted previously, Dr. Turner's October 2, 2014 ultrasound report was missing from Ms. Monroe-Lynch's medical record, despite an MFM's duty to report ultrasound results to the patient's OB/GYN.[164] According to Dr. Atlas, the plaintiff's MFM expert, failure to do so represents a breach of the standard of care, because "it's critical to be able to send

---

[162] Tr. of Dr. Park, 11/17/2020 at p. 6, ll. 17-27 and p. 7, ll. 1-4, p. 69, ll. 23-27; Trial Testimony of Ms. Deborah Hintz, 11/20/2020,28 p. 4, ll. 15-27.
[163] Tr. of Dr. Park, 11/17/2020 at p. 7, ll. 14-27; Tr. of Dr. Prince, 11/19/2020 at p. 12, ll. 20-27 and p. 13, ll. 1-21.
[164] Tr. of Dr. Atlas, 11/20/2020 at p. 49, ll. 7-13; Tr. of Dr. Parry, 12/02/2020 at p. 59, l. 27 and p. 60, ll. 1-5.

information to the doctor who's caring for the patient."[165] Effective communication is therefore especially important in the "team" operation at UCONN, employed in the relationship between the OB/GYN and MFM departments,[166] and is a requirement of the standard of care.[167] This standard of care is specifically applicable with regard to ultrasound reports and, moreover, there is a joint duty to be certain that the report gets from the MFM to the OB/GYN.[168]

According to the plaintiffs' OB/GYN unopposed expert, Dr. Prince, the standard of care requires that an OB/GYN in a group practice familiarize him or herself with the patient prior to treatment, especially in a twin and/or high risk pregnancy, by reviewing all of the pertinent lab values and studies and ensuring that all the studies that are supposed to be in the chart are in fact in the chart. It is also the OB/GYN's responsibility to be sure that patients attend and complete their scheduled sonograms.[169] Yet no provider from the OB/GYN department made an attempt to locate a copy of the October 2, 2014 ultrasound report, or to determine whether the ultrasound had taken place, prior to or during Jean's October 20, 2014 follow up appointment with Dr. Park, who should have realized the ultrasound had occurred and the report was missing.[170] Therefore,

---

[165] Tr. of Dr. Atlas, 11/20/2020 at p. 50, ll. 11-16.
[166] Tr. of Dr. Park, 11/17/2020 at p. 44, ll. 9-23.
[167] Tr. of Dr. Prince, 11/19/2020 at p. 10, ll. 23-27 and p. 11, ll. 1-8, p. 17, ll. 18-25, p. 28, ll. 19-27 and p. 29, l. 1; Tr. of Dr. Parry, 12/02/2020 at p. at p. 60, ll. 6-9. Effective communication between and amongst departments is a requirement of the standard of care. Tr. of Dr. Prince, 11/19/2020 at p. 10, ll. 23-27 and p. 11, ll. 1-8, p. 17, ll. 18-25, p. 28, ll. 19-27 and p. 29, l. 1; Tr. of Dr. Parry, 12/02/2020 at p. 60, ll. 6-9. The standard of care also requires the OB/GYN to communicate with the MFM department. With regard to ultrasound reports, there is a joint duty to be certain that the report gets from the MFM to the OB/GYN. Tr. of Dr. Prince, 11/19/2020 at p. 10, ll. 23-27 and p. 11, ll. 1-8, p. 17, ll. 18-25, p. 28, ll. 19-27 and p. 29, l. 1, p. 29, ll. 8-22, p. 30, ll. 17-27 and p. 30, ll. 1-2.
[168] Tr. of Dr. Prince, 11/19/2020 at p. 10, ll. 23-27 and p. 11, ll. 1-8, p. 17, ll. 18-25, p. 28, ll. 19-27 and p. 29, l. 1, p. 29, ll. 8-22, p. 30, ll. 17-27 and p. 30, ll. 1-2.
[169] Tr. of Dr. Prince, 11/19/2020 at p. 29, ll. 8-22, p. 30, ll. 17-27.
[170] Tr. of Dr. Prince, 11/19/2020 at p. 29, ll. 23-27 and p. 30. See Exhibits 53, 35 and 32; Tr. of Dr. Park, 11/17/2020 at p. 35, ll. 17-27, pp. 36-7, and p. 38, ll. 1-11.

no one from the UCONN OB/GYN department reviewed the findings of hyperechoic bowel and small head circumference, either internally or with the Lynches, which would have resulted in follow-up testing and discussion of an option to terminate.[171]

According to the plaintiff's unopposed OB/GYN expert, Dr. Prince, a reasonable OB/GYN physician reviewing the October 2, 2014 ultrasound report would have found it required a follow up investigation, due to the findings both of hyperechoic bowel and head circumference of less than the 5th percentile.[172] Furthermore, Dr. Park was aware that CMV posed a risk to pregnant women, and that both small head circumference and hyperechoic bowel were ultrasound markers associated with CMV.[173] Dr. Prince additionally opined that the findings of the October 2, 2014 ultrasound required an OB/GYN to rule in or out CMV infection, including ordering immediate blood testing and offering amniocentesis, which were not done by the UCONN OB/GYN team.[174]

Dr. Prince testified that this breakdown in communication was a breach of the standard of care for the OB/GYN department, as "it is important that if there are any issues involved in any patients, that those issues be brought to light with all of the physicians or practitioners that are taking care of that patient and certainly any concerns regarding a patient, especially a high risk patient that are joint concerns with maternal fetal medicine there should be communications between the generalist and the specialist."[175] The court therefore finds the defendant liable for medical malpractice for a violation of the standard of care for the MFM and OB/GYN team's

---

[171] Tr. of Dr. Park, 11/17/2020 at p. 44, ll. 24-27, p. 45, and p. 46, ll. 1-3.
[172] Tr. of Dr. Prince, 11/19/2020 at p. 22, ll. 1-19, p. 27, ll. 15-27 and p. 28, ll. 1-6.
[173] Tr. of Dr. Park, 11/17/2020 at p. 8, ll. 18-22, p. 11, ll. 22-27 and p. 12, ll. 1-2.
[174] Tr. of Dr. Prince, 11/19/2020 at p. 23, ll. 23-27 and p. 24, ll. 1-12.
[175] Tr. of Dr. Prince, 11/19/2020 at p. 11, ll. 1-8.

failure to communicate effectively, resulting in their failure to diagnose congenital CMV in the twin fetuses and timely offer termination within the twenty-fifth week of gestation, either in Connecticut or elsewhere.

VI

DAMAGES

A

Preliminary Considerations

Damages claimed by the plaintiffs total more than $70,000,000. The defendants object to the finding of any damages by the court for several reasons, as follows: The defendant first asserts that the plaintiffs' essential claims are for wrongful life and are therefore not recoverable under Connecticut law. This claim was dispelled early in this litigation by the court's denial of the defendant's motion to strike. Entry No. 214, *Cobb, J.* This issue was also raised as a motion in limine, later denied by this court as the law of the case. Entry No. 263.86. In connection with this issue, the defendant has asserted the plaintiffs have produced no evidence that, had a different sperm donor been used, the twins would have enjoyed healthy lives. The defendant concludes, to the contrary, that had a different sperm donor been used, neither Joshua nor Shay would have been conceived and there would be no damages. The court has rejected this etiological argument against the possibility of compensatory damages. In doing so, the court has concluded that the defendant's failure to obtain informed consent and medical malpractice have resulted in damages.

The defendant has additionally challenge portions of the damages claimed by the plaintiffs. For example, the defendant contends that since health insurance has paid for the medical expenses claimed, and the plaintiffs are not legally obligated to pay the cost of the medical bills, they cannot recover these medical expenses as damages. The court agrees, in part, but only to the extent there may be a collateral source hearing, not currently before the court. The defendant further contends that the adult plaintiffs cannot claim substantial economic damages for Joshua's support, including paying for future medical expenses, after he reaches the age of 18. To the extent that economic damages are awarded for Joshua's medical treatment and care, however, they are awarded pursuant to count one, brought on behalf of Joshua by his parents, PPA, pursuant to parens patriae jurisdiction.

The defendant's more significant objection to plaintiffs' evidence of damages is that the court should disregard the opinions expressed by Joshua's treating pediatric neurologist, Dr. Elizabeth Barkoudah, and pediatrician, Dr. Julie Schiff, as they were never properly disclosed pursuant to Practice Book 13-4. The defendant further asserts that, should the court allow their testimony, neither are qualified to render opinions regarding a causal link between Joshua's diagnosis of congenital CMV and the claimed injuries in this case, as the treatment and diagnosis of congenital CMV is not within the specialties of general pediatrics or pediatric neurology.

This question originally arose by way of a "Motion in Limine To Preclude Expert Testimony and All Records That May Be Offered in Evidence in Lieu of Expert Testimony."[176] In the motion, the defendant asserted that the plaintiffs "have not disclosed any expert to address the causal connection between the twins' diagnosis of congenital CMV and the claimed injuries in this case." The defendant additionally objected to the disclosure of these voluminous records

[176] See Entry No. 272.00.

as trial exhibits on October 7, 2020, leaving little time to depose these treating physicians before trial, despite the fact that these records were originally and continuously disclosed during discovery, beginning years earlier in 2016.

The plaintiffs objected to the motion pursuant to Connecticut Practice Book Section 13-4 (b) (2),[177] because the plaintiffs' treating physicians are fully and properly disclosed experts by way of the production of the plaintiffs' medical records. In ruling on the motion, the court concluded that "[i]n a medical malpractice action, [e]xpert medical opinion evidence is usually required to *show the cause of an injury* or disease because the medical effect on the human system of the infliction of injuries is generally not within the sphere of the common knowledge of the lay person. . . . *Such expert opinion may be provided through a signed report of a treating physician in lieu of live testimony*, as long as the defendant is afforded an opportunity to cross-examine the author of the report." (Citations omitted; emphasis added; internal quotation marks omitted.) *Milliun* v. *New Milford Hospital,* 310 Conn. 711, 725–26, 80 A.3d 887 (2013), citing General Statutes Section 52–174 (b), Practice Book § 13–4 (a) and (d) (1) and *Struckman* v. *Burns*, 205 Conn. 542, 552, 534 A.2d 888 (1987). "Ordinarily a trial court must determine the qualifications of a proposed expert before he may testify. . . . The legislature, however, may allow the introduction of the opinion of an expert without the need to lay a detailed foundation as to qualifications. Hospital records can be admitted into evidence without any live testimony about whether the persons who prepared or signed the records were qualified to render the expert

[177] Practice Book Section 13-4 (b) (2) provides, in relevant part: "If the witness to be disclosed hereunder is a health care provider who rendered care or treatment to the plaintiff, and the opinions to be offered hereunder are based upon that provider's care or treatment, then the disclosure obligations under this section may be satisfied by disclosure to the parties of the medical records and reports of such care or treatment. A witness disclosed under this subsection shall be permitted to offer expert opinion testimony at trial as to any opinion as to which fair notice is given in the disclosed medical records or reports."

opinions therein if the three requirements for business records are met. (Citations omitted.) *Struckman* v. *Burns*, 205 Conn. 542, 552–53, 534 A.2d 888 (1987), citing General Statutes §§ 52–180 and 4–104.

In *Struckman* v. *Burns*, supra, 205 Conn. 552, however, the court held that "[s]ection 52–174 (b) *does not deprive a defendant of his right of cross-examination.* . . . At least for one in the position of the defendant, to whom as an agent of the state its ample resources are available, the additional expense involved in taking a deposition is not a matter of constitutional concern." (Emphasis added.) Id. In light of the fact that the defendants had yet to depose these treating physicians, the plaintiffs were ordered to immediately disclose the specific treatment records they planned to submit on the issue of causation. In light of the voluminous nature of the reports, the court further ordered that the reports were to be identified, and, if necessary, grouped, by treating physician and date of treatment.

The defendant generally asserts that the treating physicians went far beyond the four corners of their written records in their depositions, for the first time just days before trial, and claimed that Joshua's medical issues were caused by his congenital CMV. From this assertion, the defendant now claims that it did not have fair notice of these opinions prior to trial and they should not be considered by the court. Importantly, the plaintiffs' treating physicians were disclosed through discovery, beginning in 2016, and retained medical experts were disclosed in 2018 "to testify on the issues of causation and damages." See Entries 163, 165 & 166, disclosing Dr. Atlas, Dr. McMeeking and Dr. Prince.

In early September, 2020, the defendant moved to continue the trial due to COVID, then scheduled for October 20, 2020. The reason for the continuance involved the logistics of

conducting depositions and trial testimony virtually. The court denied the motion on September 11, 2020. In denying the motion, the court framed the issue as follows: "This medical malpractice matter is scheduled for a court-side trial on October 20, 2020. It has been scheduled for trial on five previous occasions, and was most recently continued from a June 2, 2020 trial date, due to the State of Emergency related to the COVID-19 pandemic. The plaintiffs seek a determination that they may proceed to call their trial witnesses virtually, pursuant to Practice Book § 23-68, which is opposed by the defendants. The dispute between the parties generally involves the comparative efficacy of in-person verses the virtual examination of witnesses. Of particular concern to the defendants is their right to cross-examine witnesses in person, either in court or in remote locations involving video-taped trial testimony. The defendants also seek a continuance of the trial date, which is opposed by the plaintiff."

The defendants' motion for continuance was denied and the plaintiffs' motion for virtual appearances pursuant to Practice Book § 23-68 was granted.[178] Entry No. 253. The court also notes there was no subsequent motion for continuance made by the defendant for the purpose of either deposing the plaintiffs' experts or further disclosing their own experts on causation.[179] For other reasons, the trial was continued to November 3, 2020.[180]

---

[178] On a motion for reconsideration the court clarified that its "order is intended to prevent, by compulsion, any witness or attorney to be in each other's physical presence for the purpose of these proceedings, during the COVID-19 pandemic. They may, instead, make use of an interactive audiovisual devise, as provided by Practice Book §23-68." Entry No. 254.86.
[179] Such a motion was anticipated by the court but was not requested or filed by the defense.
[180] The defendant made the following conclusory statements regarding damages: 1) "In this case, Plaintiffs produced no evidence that, had a different sperm donor been used, Joshua and/or Shay would have enjoyed healthy lives. To the contrary, if a different sperm donor had been used, neither Joshua or (sic) Shay would have been conceived." 2) "The adult Plaintiffs are claiming substantial economic damages that they claim are the result of having to support Joshua, including paying for future medical expenses, after he reaches the age of 18. These alleged damages are not recoverable." 3) "If the Court does reach the issue of damages, the Court

B

Causation and Damages

All four plaintiffs have suffered injuries as a result of the defendant's negligence. By a preponderance of the evidence in the record, the court reaches the following factual conclusions:[181] Shay died in utero as the result of Congenital CMV.[182] Since his birth, Joshua has faced devastating medical and developmental challenges[183] during his short life and will,

---

should disregard the opinions expressed by Joshua's treating pediatric neurologist, Dr. Elizabeth Barkoudah, and pediatrician, Dr. Julie Schiff, as they were never properly disclosed pursuant to Practice Book 13-4. . . . Further, the opinions expressed by these treaters are purely speculative and not sufficiently reliable to meet the admissibility standard for expert opinions." And 4) "In this case, the adult plaintiffs did not have to pay Joshua's medical bills because they arranged for health insurance to pay those costs. Since they were the recipients of the medical treatment and are not legally obligated to pay the cost of the medical bills, they cannot recover as damages the amount of the medical bills." These issues have been addressed by the court.

[181] These conclusions are based largely upon the credible testimony of Joshua's pediatric neurologist, Dr. Barkoudah, as well as Joshua's hospital records, including those of Dr. Robert Keder, his treating Developmental-Behavioral Pediatrician. In addition, the court additionally relies upon the credible causation testimony of Dr. Atlas, Dr. McMeeking and Dr. Prince

[182] Upon delivery, Shay underwent autopsy at John Dempsey, while Joshua was rushed to the neonatal intensive care unit (NICU) with systemic, severe deficits. See Exhibit 25; Tr. of Ms. Monroe-Lynch, 11/03/2020 at pp. 71-73. The autopsy confirmed that Shay had died from severe congenital CMV infecting multiple organs, and blood tests revealed that Joshua was also suffering the effects of severe congenital CMV. See Exhibits 25 and 51; Tr. of Dr. McMeeking, 11/12/2020 a.m. at p. 68, ll. 13-26.

[183] Specifically, the evidence shows the following facts, found by the court. During his NICU admission, Joshua was also diagnosed with respiratory distress, tachypnea, direct hyperbilirubinemia, thrombocytopenia, anemia, cholestasis, hepatitis, a hydrocele, and hypocalcemia. Exhibit 110, Bates 2687-2690. Congenital CMV is the cause of Joshua's thrombocytopenia. Exhibit 110, Bates 2907, 2939, 3198. Congenital CMV is the cause of Joshua's direct hyperbilirubinemia and hepatitis. Exhibit 110, Bates 2947, 3198, 6670, 7389, 7893, and others; Tr. of Dr. Schiff, 11/18/2020 at p. 7, l. 27 and p. 8, ll. 1-17. Joshua also suffers from neutropenia which places him at increased risk for infections. Tr. of Dr. Schiff, 11/18/2020 at pp. 7-8, p. 20, ll. 4-27, p. 21, ll. 1-8, p. 27, ll. 1-8; Exhibit 110, Bates 3248. Congenital CMV is the cause of Joshua's neutropenia. Exhibit 110, Bates 3248; Tr. of Dr. Schiff, 11/18/2020 at pp. 7-8, p. 20, ll. 4-27, p. 21, ll. 1-8, p. 27, ll. 2-8. Joshua has suffered numerous infections throughout his life, requiring ED examinations and hospital admissions. Exhibit 110, Bates 3210-3232, 3236-3316, 3636-3688, 3747-3918, 3943-3993, 4038-4070, 4071-4100, 4101-4126, 4274-4361, 4430-4488, 4988-5025, 5194-5237, 5259-5278, 5289-5313, 5455-5479, 5480-5556,

more likely than not, live the rest of his life fighting the widespread sequelae of his congenital CMV infection.[184] Because of their loss of Shay, as well as Joshua's severe illnesses and cognitive deficiencies, the daily burdens associated with caring for Joshua have resulted in agonizing emotional distress for both parents, suffered from the moment they discovered that Shay had passed away, in utero, and then awaiting the emergency caesarian birth of Joshua hours later and the removal of Shay's body. The record is replete with evidence of the parents' noneconomic damages in relation to Shay's death and in caring for Joshua.[185]

The defendant's general theory of the case is that there is no causal relationship between the IUI procedure performed by CARS and the CMV infections suffered by Ms. Monroe-Lynch, Shay and Joshua. The defense has therefore left the plaintiffs to their proof of the causal relationship between the CMV infections Shay and Joshua suffered, in utero, and their subsequent sequelae, especially with regard to Joshua. The court concludes that overwhelming evidence in this case supports the conclusion that Shay died of congenital CMV and that Joshua

---

6056-6376, 6406-6442, 6480-6514, 6515-6530, 6607-6652, 6653-6928, 7608-7668, 7761-7782; Exhibit 111, Bates 8067-8390. Congenital CMV is the cause of Joshua's infections. Tr. of Dr. Schiff, 11/18/2020 at pp. 34, ll. 19-27 and p. 36, ll. 1-12. Because of his neutropenia, bloodwork must be drawn when Joshua has a fever to ascertain his neutrophil count before determining if he can be treated outpatient or if hospitalization is required. Tr. of Dr. Schiff, 11/18/2020 at p. 20, ll. 17-26. Joshua will require follow-up by hematology for the rest of his life at least every three months. Exhibit 280, Bates 18683. Joshua will require annual follow-up by infectious disease for the rest of his life. Exhibit 280, Bates 18684.

[184] Joshua's August 2015 and October 2016 brain MRIs revealed white matter changes consistent with CMV. Tr. of Dr. Barkoudah, 11/10/2020, 41 p. 37, ll. 20-27 and p. 38, ll. 1-22. Joshua also has microcephaly. Exhibit 110, Bates 3243, 3751; Exhibit 111, Bates 7864, 8007, 8420, 9083; Tr. of Dr. Barkoudah, 11/10/2020 at p. 36, ll. 19-23. Most long-term sequelae of congenital CMV are neurologic in nature because congenital CMV injures the brain at a critical time of development. Tr. of Dr. Barkoudah, 11/10/2020 at p. 22, ll. 5-13.

[185] The defendants have focused the court's attention upon Ms. Monroe-Lynch's underlying mental health problems and treatment, making uncertain her economic damages for mental health treatment resulting from Shay's death and Joshua's illnesses.

has suffered the devastating consequences of congenital CMV and will continue to do for the remainder of his life.

The court now turns to the damages for each of the plaintiffs, beginning with Shay, represented here by her estate.

C

Shay

On January 13, 2015, during a routine prenatal test thirty-seven weeks into her pregnancy, Ms. Monroe-Lynch was informed that her daughter, Shay, was not registering a heartbeat and had died, in utero.[186] The decision was made to deliver both twins by caesarian section. When Shay underwent autopsy at John Dempsey Hospital, it was definitively determined that she had died from severe congenital CMV, infecting multiple organs.[187]

The defendant moves to exclude the testimony of Dr. Gary M. Crakes concerning the economic value of household services of the decedent. The first assertion made is that this

---

[186] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 68, ll. 1-23, p. 69, ll. 21-26.

[187] "[W]here a fetus has reached that stage of prenatal development where it is capable of independent life apart from its mother, such a stage of development as to permit continued existence, under normal conditions, outside of the womb, if such child dies in the womb as the result of the negligence of some third person, then the personal representative of that child may, under the provisions of §§ 52-555 and 52-599 of the General Statutes, maintain a cause of action in its behalf for such injuries and death." *Gorke* v. *Le Clerc*, 23 Conn. Supp. 256, 262, 181 A.2d 448 (January 31, 1962, *House, J.*). General Statutes § 52-555 (a) provides: "In any action surviving to or brought by an executor or administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages together with the cost of reasonably necessary medical, hospital and nursing services, and including funeral expenses, provided no action shall be brought to recover such damages and disbursements but within two years from the date of death, and except that no such action may be brought more than five years from the date of the act or omission complained of."

element of just damages is not within the scope of General Statutes §52-555 (a), which provides in relevant part: "In any action surviving to or brought by an executor or administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages together with the cost of reasonably necessary medical, hospital and nursing services, and including funeral expenses . . . ."

The court concludes that the term "just damages" does not necessarily exclude household services, leaving that term to be applied by the trier of fact. See, e.g., *Mahon* v. *B.V. Unitron Mfg., Inc.,* Superior Court, judicial district of Waterbury, Complex Litigation Docket, Docket No. X01 CV 99 0164084 S (December 17, 2004, *Sheedy, J.*), rev'd on other grounds, 284 Conn. 645, 935 A.2d 1004 (2007) (stating that "[t]he jury was free to reject the value [Crakes] attributed to household services each provided the other . . ."); *New Hampshire Ins. Co.* v. *Estate of Parkin*, Superior Court, judicial district of Hartford–New Britain at Hartford, Docket No. 70 14 80 (December 13, 1990, *Koletsky, J.*) (3 Conn. L. Rptr. 572, 572) (affirming an arbitration award despite the argument that "the arbitrators made an error of law in permitting certain evidence concerning the economic value of household services to be introduced at the arbitration hearing"); *Sawicki* v. *New Britain General Hospital,* Superior Court, judicial district of Hartford, Complex Litigation Docket, Docket No. HHD X07 CV 02 0818629S, *6 (November 7, 2014, *Dubay, J.*).

The defendant submits that existing superior case law does not include such damages for a child who did not survive a pregnancy, because the quantification of those services would have no factual basis and therefore would be merely speculative. The court agrees and declines to award damages for household services.

The defendant next contends that Dr. Crakes' appraisal of Shay's lost earnings should be rejected as speculative. At trial, the plaintiffs offered evidence of the economic losses of Shay's estate. First, the plaintiffs claim funeral expenses of $1,021.00.[188] This claim is granted.

Second, the plaintiffs seek Shay's lost earnings, discounted to present value, either as a female high school graduate in the amount of $1,759,369, 2,267,817, as a female with a bachelor's degree, or $2,414,756 as a female with a master's degree. The plaintiffs therefore assert that Shay's economic damages total between $1,760,390 and $2,415,777.[189] This claim of damages is denied. In support of this claim, the plaintiffs contend that Connecticut courts have widely recognized the soundness of such evidence, holding that exactitude as to the lost future earnings of minor plaintiffs is neither required nor possible. In *Jackiewicz* v. *United Illuminating Co.*, 106 Conn. 310, 138 A. 151 (1927), the Supreme Court held that the trial court committed error in setting aside a minor plaintiff's lost earning capacity claim. The court held that "[t]o procure evidence of the future earning capacity of a child of tender years, would, in most cases, be impossible, and result in the denial of a recovery by a parent for such loss. At best the ascertainment of the loss for a personal injury to an adult is difficult and incapable of exact measurement, but in the case of the minor child it depends upon so many contingencies as to be incapable of definite ascertainment, and must be largely an estimate based upon conjecture and speculation, weighed in the light of experience, and left upon the facts proven, to the sound judgment, experience, and conscience of the trier, court, or jury, whose judgment or verdict will not be disturbed unless it be so unreasonable as to be excessive. . . " Id. at 312.

---

[188] Exhibit 143, Bates 18240.

[189] Exhibit 284, Bates 18798-18799; Trial Testimony of Gary Crakes, PhD, 11/24/2020, p. 169, ll. 5-12.

Our Supreme Court has also held "[i]t is not of controlling significance that the plaintiff was receiving no wages . . . at the time of the injury. . . . Recovery of damages for loss of earning capacity is not merely a recovery for wages lost. Salary or wages earned at the time of the injury are merely evidential facts, relevant but not conclusive, in the inquiry as to the pecuniary value of the impairment of earning capacity . . . [D]amages for loss of earning capacity may be determined by the market value of the services which she was prevented from contributing . . . ." (Citations omitted.) *Lashin* v. *Corcoran*, 146 Conn. 512, 514-515, 152 A.2d 639 (1959).

The plaintiffs claim in the present case, that the evidence of Shay's lost earning capacity satisfies the above standards, that it is entirely uncontested and therefore should be awarded. The court disagrees. The claim is contested as speculative and, moreover, an award of earning capacity serves no practical purpose. In *Jackiewicz*, for example, the claim was for loss of earnings of a child injured through the alleged negligence of defendant. In *Lashin*, the plaintiff was a partner in grocery store with her husband and son. Due to her injuries, she was unable to work in the store for almost fifteen months, and after that time she was able to work only part time. The cases cited by the plaintiffs are therefore distinguishable in an important way, in that the diminished earning capacity found in those cases was to supplant an income relied upon or needed for a person's ongoing expenses and rightful economic expectations, deprived by the tortfeasor.

Shay neither worked nor would have benefited from the accumulation of wages for her own use and estate. Although Joshua will likely never work as well, by dramatic contrast he would have to exist without an income to support his life, absent compensation for lost work capacity. Lost earnings and earning capacity has purposeful meaning in this context, to

compensate an individual for true economic losses. The court therefore declines to find there are damages for Shay's loss of earning capacity.

Shay's most significant claim is her loss of life. The plaintiffs claim that Shay is entitled to compensation for the pain and suffering associated with acquiring, fighting, and ultimately succumbing to congenital CMV, in utero. Fortunately, there is no evidence in the record of Shay's distress or suffering, in utero. The plaintiffs also claim that her estate is entitled to compensation for the loss of her life, with which the court agrees. It is uncontested that Shay's life expectancy was 80.96 years had she survived. For this, the court awards $1,000,000 to her estate for her loss of the gift of life pursuant to count two of the complaint.

D

Joshua

The plaintiffs have shown by sufficient evidence that Joshua continues to suffer the consequences of Congenital CMV.[190] He cannot eat normally, communicate effectively,[191] use

[190] A maternal CMV infection during pregnancy causes congenital CMV in 40% of fetuses, which can result in catastrophic neurodevelopmental sequelae in the baby including organ damage, cerebral palsy, intellectual disability, vision impairment, seizures, and sensorineural hearing loss. Congenital CMV can also lead to fetal demise. Tr. of Dr. Schust, 11/13/2020 at p. 4, ll. 5-27 and p. 5, ll. 1-27; Tr. of Dr. Shamonki, 12/03/2020 at p. 62, ll. 7-16; Tr. of Dr. Benadiva, 11/05/2020 at p. 125, ll. 22-27 and p. 126, ll. 1-4; Tr. of Dr. Schleiss, 12/10/2020 a.m., p. 18, ll. 5-18, p. 20, ll. 2-8.

[191] Joshua has severe deficits in communication skills, extreme difficulty coping with change, restricted/repetitive behaviors which markedly interfere with functioning in all spheres, and great distress/difficulty changing focus or action. Robert Keder, M.D., Exhibit 110, Bates 6567-6568 and 7680-7681.

the bathroom typically,[192] attend to any of his personal needs, or maintain his own safety.[193] Consistent with congenital CMV, he has global developmental delay,[194] continuing cognitive deficits,[195] hearing deficits, motor deficits, and autism with related acts of self-stimulation, or "stimming."[196] The court also finds that he spends hours every day having nutrition pumped into him through his G-tube. This is the method by which he has and will receive all of his nutrients for the remainder of his life.[197]

---

[192] Joshua is not toilet trained but does intermittently void in the toilet. He has outgrown regular diapers and wears prescription diapers. Tr. of Mr. Lynch, 11/25/2020 at p. 16, ll. 8-27; Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 92, ll. 2-3; Tr. of Ms. Poudrier, 12/01/2020 at p. 111, ll. 21-27 and p. 112, ll. 1-24; Exhibit 113, Bates 9283.

[193] Joshua has poor safety awareness and is an escape risk. Exhibit 110, Bates 5159, 6937, 7183, 7802; Exhibit 111, Bates 9037 and 9047. The doors at Aaron and Jean's house have safety locks because Joshua bolts. The outside doors have chains on top so Joshua cannot get out of the house because he does not understand safety. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 137, ll. 7-15. Joshua does not understand that the stove is hot. Tr. of Mr. Lynch, 11/25/2020 at p. 12, ll. 3-7. Joshua must be watched 24 hours a day, 7 days a week. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 137, ll. 7-8; Tr. of Ms. Poudrier, 12/01/2020 at p. 122, l. 27 and p. 123, ll. 1-2. Joshua will likely require 24 hour a day care for the rest of his life. Tr. of Dr. Schiff, 11/18/2020 at p. 57, ll. 17-26; Exhibit 280, Bates 18682.

[194] Congenital CMV is the cause of Joshua's global developmental delay. Tr. of Dr. Barkoudah, 11/10/2020 at p. 48, ll. 12-24;

[195] Joshua will require follow-up by neurology for the rest of his life every six to twelve months barring any urgent issues. Exhibit 280, Bates 18686. Joshua will require lifelong laboratory studies at least once a year for ongoing monitoring of his laboratory values due to his medications. Exhibit 280, Bates 18686.

[196] Joshua exhibits numerous physical and audible self-stimulating, or "stimming", behaviors because of his autism. He hits his head with his hands, slams his head against walls and the floor, and hits others. Frustration exacerbates these behaviors. Joshua's self-injurious behaviors have increased as he has gotten older and with COVID confinement. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 137, ll. 16-27 and p. 138, ll. 1-8; Tr. of Mr. Lynch, 11/25/2020 at p. 10, ll. 9-26, p. 20, ll. 10-24; Tr. of Aaron Lynch, 12/01/2020,43 p. 91, ll. 6-24; Trial Testimony of Janette Poudrier, 12/01/2020,44 p. 121, ll. 22-27 and p. 122, ll. 1-13; Exhibit 110, Bates 6974, 7508, 7521, 7823, 7832, 7834, and others; Exhibit 111, Bates 8910-8911, 8961, and others; and Exhibit 119, Bates 10001, 12391, and others; Exhibit 311, Bates 19041. One of Joshua's stimming behaviors is flushing toilets. When Joshua shows interest in the bathroom, it is to flush the toilet and stim to the water. Exhibit 110, Bates 7027, 7601, and 7676; Tr. of Mr. Lynch, 11/25/2020 at p. 17, ll. 1-5.

[197] Joshua's has significant oropharyngeal dysphagia with oral motor and oral sensory deficits and aspiration. Congenital CMV is the cause of Joshua's feeding difficulties and G-tube

The court also finds by sufficient evidence presented that Joshua is unable to communicate his needs, is continually susceptible to infection and vulnerable to injurious behaviors towards himself and others. As the result of his condition, he also suffers from seizures.[198] Joshua also suffers from other neurologic deficits and diagnoses related to

---

dependence. Tr. of Dr. Barkoudah, 11/25/2020 at p. 110, ll. 21-27 and p. 115, ll. 7-19. Exhibit 110, Bates 3515, 3549, 5096, 5100, 5149; Exhibit 111, Bates 7970, 8020, 8688. Joshua was evaluated at Boston Children's Hospital for feeding difficulties after having trouble taking bottles and losing weight at around four months of age. Tr. of Dr. Schiff, 11/18/2020 at p. 43, ll. 18-27, p. 44, and p. 45, ll. 1-2. The initial plan was to conduct a nasogastric (NG) tube trial and then to place a gastrostomy (G) tube and, if necessary, convert to a gastrostomy-jejunostomy (G-J) tube. Exhibit 111, Bates 7962. As planned, an NG-tube was initially placed. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 84, ll. 21-27 and p. 85, ll. 1-2; Exhibit 111, Bates 7962; Exhibits 174, 176, 183, and 184, Bates 18275, 18277, 18286, and 18287. The NG-tube was replaced multiple times because Joshua kept pulling it out. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 86. He screamed, cried, and required restraint by nursing staff each time the NG-tube was placed. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 87, ll. 1-3. After the NG-tube trial, a G-tube port was surgically placed in Joshua's stomach. Exhibits 213, 216, and 239-244, Bates 18316, 18319, and 18345-18350. Joshua gets four feeds during a day and one feed overnight. The feeds take hours throughout the day. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 89, ll. 15-23; Tr. of Mr. Lynch, 11/25/2020 at p. 5, ll. 20-27 and p. 6, ll. 1-10. Joshua frequently attempts to pull his G-tube out. Tr. of Mr. Lynch, 11/25/2020 at p. 33, ll. 1-6; Tr. of Ms. Poudrier, 12/01/2020 at p. 114, ll. 1-14. He has had skin breakdown and numerous infections of the G-tube site. Tr. of Dr. Schiff, 11/18/2020 at p. 45, ll. 3-9; Exhibit 110, Bates 3636-3688, 3943-3993, and others; Exhibit 111, Bates 8067-8389; Exhibit 113, Bates 9409-9412, 9453, and others. Joshua receives 100% of his nutrition via the G-tube. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 89, ll. 10-14; Tr. of Mr. Lynch, 11/25/2020 at p. 6, ll. 21-26; Tr. of Ms. Poudrier, 12/01/2020 at p. 113, ll. 1-19. Joshua will require G-tube feeds for the rest of his life. Karan Emerick, M.D., Exhibit 280, Bates 18687; Robert Keder, M.D., Exhibit 280, Bates 18681. He will require monthly blood work for the rest of his life to monitor his GI status. Exhibit 280, Bates 18687. Joshua receives food therapy but shows no interest in food. It has been a very arduous five-and-a-half-year process for Joshua to accept bites of pudding, yogurt, and apple sauce. Joshua tolerates food but does not enjoy it. His food intake is purely therapeutic. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 90, ll. 5-14; Tr. of Mr. Lynch, 11/25/2020 at p. 12, ll. 15-20; Tr. of Ms. Poudrier, 12/01/2020 at p. 113, ll. 1-19. Joshua requires close one-to-one monitoring of all interactions with solid foods because he does not have the oral motor skills to safely consume these consistencies. It is likewise unsafe for him to accept thin liquids orally.

[198] Congenital CMV puts Joshua at a higher risk for seizures. Exhibit 110, Bates 3374, 3383, 3425; Exhibit 111, Bates 9023. Congenital CMV is the cause of Joshua's seizure disorder. Tr. of Dr. Barkoudah, 11/10/2020 at p. 53, ll. 1-12; Tr. of Dr. Barkoudah, 11/25/2020 at p. 94 ll. 25-27, p. 95, ll. 1-13, p. 101, ll. 11-15, p. 123, ll. 24-27 and p. 124, ll. 1-22, and p. 171, ll. 16-19; Robert Keder, M.D., Exhibit 110, Bates 5186, 5251, and 6568; Terrell Clark PhD, Exhibit 111,

congenital CMV, including intellectual disability, epilepsy, and cerebral palsy.[199] The underlying cause of cerebral palsy is injury to the brain at a critical point of development and, in the present matter, Congenital CMV is the cause of Joshua's cerebral palsy.[200] Joshua has fluctuating muscle tone due to dystonic cerebral palsy. Joshua therefore frequently exhibits dystonic posturing including back arching.[201] Congenital CMV is the cause of Joshua's generalized dystonia.[202] Joshua regularly wears ankle-foot orthotics (AFOs) for his legs to help him walk and will require AFOs for the rest of his life.[203] This constellation of conditions is consistent with and sufficiently shown to have been caused by congenital CMV.[204]

The defendant challenges the severity of Joshua's hearing impairment, which has shown improvement at times within recent years. Although this is hopeful news, it is negligible when

---

Bates 8675. Joshua has seizure disorder and experiences several types of seizures including grand mal seizures. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 136, ll. 2-14; Tr. of Mr. Lynch, 11/25/2020 at p. 18, ll. 13-27 and p. 19, l. 1; Tr. of Ms. Poudrier, 12/01/2020 at p. 119, ll. 19-21, p. 120, ll. 4-27, p. 121, ll. 1-11; Exhibit 119, Bates 12404; Exhibit 110, Bates 4945, 5680-5681, 7072; Exhibit 111, Bates 9047, 9071, and 9084. On medication, he has seizures about once a month. Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 136, ll. 2-14; Exhibit 111, Bates 9047. Congenital CMV is the cause of Joshua's seizure disorder. Tr. of Dr. Barkoudah, 11/10/2020 at p. 53, ll. 1-12; Tr. of Dr. Barkoudah, 11/25/2020 at p. 94 ll. 25-27, p. 95, ll. 1-13, p. 101, ll. 11-15, p. 123, ll. 24-27 and p. 124, ll. 1-22, and p. 171, ll. 16-19; Robert Keder, M.D., Exhibit 110, Bates 5186, 5251, and 6568; Terrell Clark PhD, Exhibit 111, Bates 8675.

[199] Tr. of Dr. Barkoudah, 11/10/2020 at p. 22, ll. 18-22.

[200] Tr. of Dr. Barkoudah, 11/10/2020 at p. 55, ll. 13-15. Id. at p. 63, ll. 2-5.

[201] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 134, ll. 18-27 and p. 135, l. 1; Exhibits 181 and 182, Bates 18283 and 18284; Exhibits 257 and 260; Exhibit 111, Bates 7894 & 8007.

[202] Id. at p. 48, ll. 8-11; Exhibit 111, Bates 8446 and 8964.

[203] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 135, ll. 2-3; Tr. of Mr. Lynch, 11/25/2020 at p. 17, ll. 10-19; Exhibit 110, Bates 4259, 4575, 7699; Exhibit 280, Bates 18686.

[204] A unifying diagnosis explains the list of a patient's medical problems. Tr. of Dr. Barkoudah, 11/10/2020 at p. 40, ll. 1-4. Joshua's unifying diagnosis is congenital CMV. Nicole Randazzo-Ahern, M.D., Exhibit 111, Bates 7862; Tr. of Dr. Barkoudah, 11/25/2020 at p. 123, ll. 25-27, and p. 124, ll. 2-22.

compared with his other ruinous neurological maladies, caused by CMV. His hearing impairment is nonetheless related to congenital CMV.[205]

Of his more serious conditions, Joshua's diagnosis of Autism is a debatable consequence of his CMV infection, although it is suspected to be one of many other, well-known consequences of congenital CMV. The defendant's infectious disease expert, Dr. Schleiss, has also concluded in published literature that CMV may cause autism, as well as many other maladies Joshua faces on a daily basis. Dr. Schleiss has written that "[l]ong-term disabilities due to congenital CMV can include seizures, cerebral palsy, mental retardation, and developmental delay . . . Other neurodevelopmental results, including behavior disorders and autism, *may* be caused by congenital CMV." (Emphasis added.) Entry 274, Exhibit F, "Cytomegalovirus A disabling virus in babies," Schleiss, M., Minnesota Health Care News, May 2012. At trial, Dr. Schleiss testified that a causal connection between Autism and congenital CMV is under investigation but that, to date, no one has proven that such a causal connection exists.[206]

The defendant contends that the plaintiffs have not disclosed any expert opinions that Joshua's diagnosis with CMV at birth is the proximate cause of his Autism Spectrum Disorder (ASD). It contends that without an expert to correlate the CMV diagnosis to the alleged ASD, any such comments regarding ASD are speculative, prejudicial and must be excluded.

---

[205] One of the most common neurologic sequelae of congenital CMV is sensorineural hearing loss. Tr. of Dr. Barkoudah, 11/10/2020 at p. 22, ll. 14-16. Congenital CMV is the cause of Joshua's sensorineural hearing loss. Id. at p. 50, ll. 2-27 and p. 51, ll. 1-6; Exhibit 113, Bates 9284; Exhibit 110, Bates 3391; Exhibit 111, Bates 8149, 8917-8, 8955, and others. The decline in Joshua's hearing after discontinuation of Valganciclovir demonstrates that CMV is the cause of his hearing loss. Tr. of Dr. Barkoudah, 11/10/2020 at p. 63, ll. 17-27 and p. 64, ll. 1-9; Exhibit 111, Bates 8537 and 8559.

[206] Tr. of Dr. Schleiss, 12/10/2020 a.m., p. 9.

The court concludes that the scientific evidence of the cause of ASD is unsettled. Scientists, such as Dr. Schleiss, have yet to be convinced that the link between congenital CMV has been proven as a matter of scientific fact, yet there is no doubt that he suspects it may be true. Part of the problem in separating out ASD from Joshua's many other profound neurological and physiological dysfunctions for purposes of damages is that there is no guidance to be discerned from the record as to where one begins and others end, such as cerebral palsy, global developmental delay and ASD, for example, and how each and not another may relate to his need for ongoing treatment. Based upon the evidence presented, however, the court finds Joshua's ASD to be related to his Congenital CMV.

Joshua's treating pediatric neurologist, Dr. Barkoudah, has concluded that congenital CMV is the cause of Joshua's autism,[207] *likely* resulting from an early injury to Joshua's brain from congenital CMV.[208] In addition, his treating developmental-behavioral pediatrician, Dr. Robert Keder, has concluded that "Joshua's presentation remains consistent with the developmental trajectory of a boy with autism spectrum disorder and an accompanying developmental delay. These *are likely related* to his congenital CMV infection." [209]

In evaluating these expert opinions, the court must be guided by the long-standing rule for probable cause in medical malpractice matters. "To be reasonably probable, a conclusion must be more likely than not. . . . Whether an expert's testimony is expressed in terms of a reasonable probability that an event has occurred does not depend upon the semantics of the expert or his use of any particular term or phrase, but rather, is determined by looking at the

---

[207] Tr. of, 11/10/2020 at p. 72, ll. 22-27 and p. 73, ll. 1-7, p. 67, ll. 22-27 and p. 68, ll. 1-4
[208] (Emphasis added.) Tr. of Dr. Barkoudah, 11/10/2020 at p. 68, ll. 11-16.
[209] (Emphasis added.) Exhibit 110, Bates 5186 and 5251.

entire substance of the expert's testimony. . . . An expert . . . need not use talismanic words to show reasonable probability." (Citations omitted.) *Sargis* v. *Donahue*, 142 Conn. App. 505, 513, 65 A.3d 20, cert. denied, 309 Conn. 914, 70 A.3d 38 (2013).

Based upon the record, there is no doubt that Joshua suffers from symptoms constituting ASD. Although there is a scientific inquiry into whether ASD is a scientifically proven sequela of congenital CMV, both of Joshua's treating physicians, Dr. Barkoudah and Dr. Keder, have concluded that congenital CMV is the likely cause of Joshua's autism.[210] As this is the uniform opinion of his treating physicians on the causation of ASD, and as they are experts in the fields of pediatric neurology and behavioral development, respectively, the record supports the court's conclusion that congenital CMV is the legal cause Joshua's ASD because it is the "likely" cause and, therefore, the probable medical cause of this neurological condition.

Joshua will require occupational therapy, physical therapy, adaptive/behavioral equipment, and home nursing/health aide throughout his life expectancy.[211] In addition, the evidence has shown that Joshua's future will mirror his past and he will face a lifetime of severe cognitive impairment, remain G-tube dependent, as well as the host of other medical problems secondary to congenital CMV.

The plaintiffs submit a normal life expectancy for Joshua of 71.53 years, supported by the opinion of Dr. Barkoudah.[212] At trial, the defendant's counsel suggested that his life expectancy

---

[210] Tr. of, 11/10/2020 at p. 72, ll. 22-27 and p. 73, ll. 1-7, p. 67, ll. 22-27 and p. 68, ll. 1-4

[211] Robert Keder, M.D., Exhibit 280, Bates 18681.

[212] Joshua was born on January 13, 2015 and is 6 years old. Exhibit 110, Bates 2685. His life expectancy is 70.54 years. Exhibit 54, Bates 1224. Joshua is expected to have a normal life expectancy if he continues receiving medically necessary treatment and services. Trial Testimony of Elizabeth Barkoudah, M.D., 11/25/2020, p. 122, ll. 10-27 and p. 123, l. 1; Tr. of Dr. Schiff, 11/18/2020 at p. 60, ll. 19-24; Exhibit 280, Bates 18682.

would be only fifty (50) years. Although plausible, the defendant offered no evidence that Joshua's life expectancy would be reduced. For this reason, the court concludes that Joshua's life expectancy is 71.53 years, as claimed. The plaintiffs nonetheless offered revised calculations of economic loss for the court's consideration, using life expectancies of fifty and sixty years. This was suggested by the court in light of the complicated calculus used in determining Joshua's net discounted economic losses. To recalculate Joshua's damages using these alternative, hypothetical life expectancies, however, is not supported by any evidence in the record and would, instead, be based upon the court's own speculation.

Joshua's parents have both achieved a significant level of higher education, both with post graduate degrees. The court therefore finds it more likely than not that he would have attained a four year college degree, but for his congenital CMV. Joshua's parents have cared for him at their home since his release from the NICU and the court finds that, given their continuing support of Joshua and their age in the mid-forties, Joshua's lifetime care costs would be best determined while he resides at home until the age of twenty-two, followed by admission to a residential facility, will total $19,262,925.[213] Joshua's lost earnings reduced to present value total $2,968,107 as a male with a bachelor's degree.[214] With earnings as a male with a college degree, Joshua's net discounted economic loss is $21,954,176 and this figure is awarded as

[213] Exhibit 281, Bates 18723-18724, 18727-18739, 18741, and 18743; Tr. of Ms. Siegel, 11/24/2020 at p. 62, ll. 10-15. Although Joshua has required numerous hospitalizations in the past, these lifetime care cost calculations do not include the costs of any future hospitalizations. Likewise, although Joshua has required numerous annual visits with his pediatrician in the past, the lifetime care cost calculations only include one annual pediatric/primary care visit. Likewise, although Joshua has suffered numerous infections in the past, the cost of related treatment and medications is not included in the lifetime care cost calculations. Likewise, all services required to be provided by Joshua's school district are not included in the lifetime care cost calculations. Exhibit 281; Tr. of Ms. Siegel, 11/24/2020 at p. 37, ll. 8-22, p. 54, ll. 7-10.

[214] Exhibit 283, Bates 18777-18779; Tr. of Dr. Crakes, 11/24/2020 at p. 157, ll. 1-3, p. 160, ll. 23-25, p. 163, ll. 5-8.

future economic damages to Joshua, through his parents, PPA.[215] For non-economic damages, the court awards $7,000,000. Joshua's past medical bills total $1,967,932, and are found to be just, due and owing, subject to General Statutes § 52-225a.[216]

E

Ms. and Mr. Monroe-Lynch

1. Emotional Distress

When she was told that Shay did not have a heartbeat on January 13, 2015, Ms. Monroe-Lynch testified that she went into shock and started screaming and crying.[217] Mr. Lynch was teaching his high school English class when he received the call from Jean's sister that they lost Shay. Mr. Lynch testified that he ran to his car and screamed, which was not enough to express what he felt at the time.[218]

During the C-section, the attending physician delivered the first baby and Ms. Monroe-Lynch heard nothing, and so she knew it was Shay. The doctor delivered Joshua and she heard a tiny little whimper. Mr. Lynch saw Joshua briefly before he was whisked away. Ms. Monroe-Lynch did not see Joshua until sometime later and both soon learned that their babies were afflicted with congenital CMV.[219]

---

[215] Exhibit 283, Bates 18778; Tr. of Dr. Crakes, 11/24/2020 at p. 161, ll. 1-13.$21,057,170
[216] Exhibit 108; Exhibit 109, Bates 1752-2684.
[217] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 68, ll. 1-23; Exhibit 303.
[218] Trial Testimony of Aaron Lynch, 11/25/2020, 35 p. 23, ll. 1-5; Exhibit 303.
[219] Tr. of Ms. Monroe-Lynch, 11/03/2020 at pp. 71-72; Tr. of Mr. Lynch, 11/25/2020 at p. 24, ll. 7-15.

Both parents attended a wake for Shay to say goodbye and so the family could meet Shay and say goodbye, as well.[220] Shay's wake was on the day Ms. Monroe-Lynch was discharged from the hospital.[221] Joshua remained in the hospital after Ms. Monroe-Lynch was discharged, and then spent her time caring for her son, Isaiah, at home and pumping breast milk because it was the only thing she could do for Joshua.[222] Since his discharge from the NICU, Joshua has had innumerable medical appointments and hospitalizations.[223] Since Joshua's return, the plaintiffs' house is a like Grand Central Station, with people constantly coming and going to provide treatment and services to Joshua.[224] Under these circumstances, Jean and Aaron's relationship is now best defined as case management, dealing with schedules of caring for Joshua, and his innumerable medical appointments.[225]

Ms. Monroe-Lynch has had a history of alcoholism, but has been sober for 21 years. She also has a history of significant psychiatric difficulties.[226] Prior to her fertility treatment, Ms. Monroe-Lynch's psychiatric symptoms were under reasonable control, generally, except upon the passing of her mother. During her fertility treatment and pregnancy, Ms. Monroe-Lynch was taken off her psychiatric medications, as they are contraindicated for prenatal care.[227] She testified that after Shay and Joshua's delivery, she experienced increased depression, grief, and post-traumatic stress. The grief she experienced for Shay and Joshua was totally new, according

---

[220] Exhibits 250 and 251, Bates 18356 and 18357.
[221] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 81, ll. 2-8; Tr. of Mr. Lynch 11/25/2020 at p. 25, ll. 4-10.
[222] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 82, ll. 22-27 and p. 83, ll. 1-14.
[223] Tr. of Mr. Lynch, 11/25/2020 at p. 26, ll. 16-18; Exhibits 110, 111, 113, 116, 117, 118, and 120.
[224] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 144, ll. 13-23; Exhibits 112, 115, and 119.
[225] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 152, ll. 1-9.
[226] Tr. of Ms. Monroe-Lynch., 11/03/2020 at p. 42, ll. 16-44.
[227] Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 147, ll. 24-27, p. 148, p. 115, ll. 26-27, p. 116, ll. 1-3 and pp. 149-150.

to her credible testimony. Ms. Monroe-Lynch additionally testified to nightmares, thoughts of wanting to be with Shay, and increased depression and anxiety. She experienced the stressors of caring for Joshua and also taking care of Isaiah and making sure he was okay too. By way of background, Ms. Monroe-Lynch had an exacerbation of psychiatric symptoms in late 2012 and early 2013, because her mom was fighting and succumbed to cancer.[228]

Ms. Monroe-Lynch remained off psychiatric medications after the delivery and while she continued to pump breastmilk for Joshua.[229] When she stopped pumping breastmilk in early 2017, she experienced a severe depressive episode and grief which necessitated extensive treatment and in-patient hospitalizations.[230] On January 19, 2017, she returned to her therapist for the first time since the delivery reporting that she was seeing her dead baby.[231]

Ms. and Mr. Monroe-Lynch were devastated by Shay's death and Joshua's medical problems. They have faced numerous resulting stressors including managing Joshua's care, physical and mental exhaustion, depression, anxiety, and grief.[232] During her January 21, 2017 to January 27, 2017 psychiatric hospitalization at Middlesex Hospital, Ms. Monroe-Lynch described seeing and hearing Shay.[233] Ms. Monroe-Lynch faced "worsening distress and psychosis in context of several stressors including likely grief reaction from recent anniversary of her daughter's death and difficulty of caring for disabled son."[234] On January 31, 2017, Ms. Monroe-Lynch returned to the Middlesex Hospital emergency department reporting ongoing

[228] Exhibit 129, Bates 15907; Exhibit 130, Bates 16809.
[229] Exhibit 123, Bates 14566; Exhibit 125, Bates 14639.
[230] Exhibits 123, 124, 125, and 126.
[231] Exhibit 123, Bates 14566.
[232] Exhibit 124, Bates 14573.
[233] Exhibit 125, Bates 14704.
[234] Exhibit 125, Bates 14641.

struggles caring for Joshua and great concern that she would be unable to properly care for him.[235] She was re-admitted to Middlesex Hospital from February 14, 2017 to February 21, 2017, after reporting a loss of her connection to Joshua and Shay and a plan to cut her wrist.[236] Due to the severity of her symptoms, Ms. Monroe-Lynch also underwent electroconvulsive therapy at Middlesex Hospital.[237] Her total, related medical expenses are claimed to total $197,897.53.[238]

After Shay and Joshua's delivery, Mr. Lynch was also deeply disturbed by Shay's death.[239] He experienced rage, sadness and numbness.[240] Mr. Lynch had prior psychiatric diagnoses which he managed with regular therapy and medication.[241] Shay's death and Joshua's medical issues exacerbated Mr. Lynch's prior psychiatric conditions.[242] Shay's death and Joshua's medical issues are the first and last thing he thinks about each day. Mr. Lynch worries every single day about Joshua, the future, and who will take care of Joshua when he gets too old.[243]

Dr. Schiff has written numerous medical necessity letters because Mr. Lynch and Ms. Monroe-Lynch's health insurance has repeatedly denied Joshua's treatment and services.[244]

---

[235] Exhibit 125, Bates 15063.
[236] Exhibit 125, Bates 15146.
[237] Exhibit 125, Bates, 15761-15800.
[238] Exhibits 121 and 122, Bates 14486-14565; Tr. of Ms. Monroe-Lynch, 11/03/2020 at p. 100, ll. 18-25.
[239] Exhibit 134, Bates 16914.
[240] Exhibit 134, Bates 16916.
[241] Exhibit 142.
[242] Exhibits 134-140.
[243] Tr. of Mr. Lynch, 11/25/2020 at p. 49, ll. 24-27 and p. 50, ll. 1-8.
[244] Trial Testimony of Julie Schiff, M.D, 11/18/2020, 39 p. 49, ll. 23-27 and p. 50, ll. 1-12.

Despite their mental health problems, the Monroe-Lynches have been extremely dedicated to Joshua.[245] Joshua's progress "is a result of his and his family's combined effort."

Ms. Monroe-Lynch's mental health history is particularly noteworthy, as she has an extensive history of mental health treatment and numerous hospital admissions, including one immediately prior to her TDI treatment at CARS. Although her extensive mental health history and medication were known to CARS at the time she began its TDI program, a recent hospitalization was not disclosed to the defendant at that time.

The court considers Ms. Monroe-Lynch an eggshell plaintiff. "The eggshell plaintiff doctrine states that [w]here a tort is committed, and injury may reasonably be anticipated, the wrongdoer is liable for the proximate results of that injury, although the consequences are more serious than they would have been, had the injured person been in perfect health. . . . The eggshell plaintiff doctrine is not a mechanism to shift the burden of proof to the defendant; rather, it makes the defendant responsible for all damages that the defendant legally caused even if the plaintiff was more susceptible to injury because of a preexisting condition or injury. Under this doctrine, the eggshell plaintiff still has to prove the nature and probable duration of the injuries sustained." *Rockhill* v. *Danbury Hospital*, 176 Conn. App. 39, 56, 168 A.3d 630 (2017), citing *Iazzetta* v. *Nevas*, 105 Conn. App. 591, 593 n.4, 939 A.2d 617 (2008) and W. Prosser & W. Keeton, Torts (5th Ed. 1984) § 43, p. 292.

Ms. and Mr. Monroe-Lynch claim damages for emotional distress. In *Marsala* v. *Yale-New Haven Hospital, Inc.,* 166 Conn. App. 432, 445, 142 A.3d 316, (2016), the Appellate Court

[245] Robert Keder, M.D., Exhibit 110, Bates 7682; See also Sandra Burchett, M.D., Exhibit 111, Bates 8980; Robert Keder, M.D., Exhibit 110, Bates 7681; Terrell Clark, PhD, Exhibit 111, Bates 8675.

clarified that the distinction between a claim for negligent infliction of emotional distress and bystander emotional distress "turns on whether the duty breached was owed directly to the plaintiff (direct) or to a third party (bystander)." With this in mind, the claim of emotional distress is granted as to Ms. Jean Monroe-Lynch, but is denied as to Mr. Aaron Lynch.

The court will begin its analysis of the claim of emotional distress, as it relates to Mr. Aaron Monroe-Lynch. The court finds him to be a bystander, without a direct claim under the facts found by the court in this matter. Connecticut permits recovery for bystander emotional distress pursuant to a theory of reasonable foreseeability, but only where "the bystander satisfies the following conditions: (1) he or she is closely related to the injury victim, such as the parent or the sibling of the victim; (2) the emotional injury of the bystander is caused by the contemporaneous sensory perception of the event or conduct that causes the injury, or by arriving on the scene soon thereafter and before substantial change has occurred in the victim's condition or location; (3) the injury of the victim must be substantial, resulting in his or her death or serious physical injury; and (4) the bystander's emotional injury must be serious, beyond that which would be anticipated in a disinterested witness and which is not the result of an abnormal response." *Clohessy* v. *Bachelor,* 237 Conn. 31, 56, 675 A.2d 852 (1996).

This general rule was substantially modified by *Squeo* v. *Norwalk Hospital Assn.*, 316 Conn. 558, 113 A.3d 932 (2015), limiting bystander emotional distress to instances of gross medical malpractice. "A number of jurisdictions have addressed these concerns by adopting the rule that bystander claims arising from medical malpractice are cognizable only in those rare cases in which the medical mistake is the result of gross negligence such that it would be readily apparent and independently traumatizing to a lay observer. . . . We believe that such a rule strikes an appropriate balance. It permits recovery by those traumatized from witnessing vulnerable

loved ones seriously injured by gross misconduct on the part of health care providers." (Citations omitted.) Id., 578–80.

By this standard, Mr. Lynch's claim of emotional distress as a bystander is denied. He generally meets the *Clohessy* test, although it may be arguable whether he was in the zone of contemporary sensory perception while Joshua was being transferred to the NICU; however, there is no claim or evidence in the record of gross negligence. Mr. Lynch has claimed medical expenses total $29,159.23.[246] This claim is denied, for reasons set forth above.

Ms. Monroe Lynch's claim of emotional distress is distinguishable from her husband's claim, in that it is a direct claim against the defendant. Decisions of the superior court are divided on the issue.[247] Upon a review of the relevant case law, this court agrees with the vast majority of superior courts, concluding that a physician providing obstetrical care owes a direct duty to a mother to prevent harm to her child during gestation and delivery.[248]

---

[246] Exhibits 132 and 133, Bates 16899-16912.

[247] "Decisions of the Superior Court are divided on the issue. The defendants refer the court to decisions that held that while defendant obstetricians owe an independent duty to the mother, negligent acts inflicted on the child are not a basis for a breach of that duty. "See, e.g., *D'Attilo* v. *Viscarello*, Superior Court, judicial district of Stamford-Norwalk, Docket No. CV054003079, 2005 Conn. Super. LEXIS 2190, *13 (August 15, 2005, *Dooley, J.*) (39 Conn. L. Rptr. 778) (court declined to find that negligence in the care of the son as a basis for breach of duty to mother where allegations supporting claim of emotional distress are those of negligence as to care of the son); *Drown* v. *Associated Women's Health Specialists, P.C.*, Superior Court, judicial district of Waterbury, Docket No. CV000159512, 2002 Conn. Super. LEXIS 4155, *3 (December 26, 2002, *Pittman, J.)* (33 Conn. L. Rptr. 562) ("the court quite agrees that the obstetrician owes a duty of care to the mother, but that duty is to render proper care to the mother, albeit during the birth process. The duty to render proper care to the infant is one that is owed to the infant itself. Only the infant can sue for a breach of duty to the infant")" *Gambacorta* v. *Williams*, Superior Court, Judicial District of Hartford, Docket No. HHDCV176077609S, 2021 Conn. Super. LEXIS 12, *7 (January 8, 2021, *Noble, J.*).

[248] The overwhelming majority of superior court cases have concluded that a mother may recover emotional distress damages for the injury or death of a child resulting from medical malpractice during delivery. See *Brown* v. *Bacall*, Superior Court, judicial district of Hartford, Docket No.

CV010811432S, 2004 Conn. Super. LEXIS 2230, *5-6 (August 10, 2004, *Booth, J.*) (a mother is not a bystander, but rather a participant in the birthing process); *Misurale* v. *Cuteri*, Superior Court, judicial district of Fairfield at Bridgeport, Docket No. CV01383788S, 2003 Conn. Super. LEXIS 752 (March 13, 2003, *Doherty, J.*) (a mother is not a bystander, but rather a participant in the birth); *Subiono* v. *Yordan,* Superior Court, judicial district of New London, Docket No. 559573, 2002 Conn. Super. LEXIS 1410, *10 (April 25, 2002, *Martin, J.*) (a woman in labor is a participant rather than a bystander of that event, permitting the mother a direct claim for emotional distress); *Johnson* v. *Day Kimball Hospital of Windham County,* Superior Court, judicial district of Windham at Putnam, Docket No. 063592, 2001 Conn. Super. LEXIS 275, *10 (January 24, 2001, *Foley, J.*) (there are two within the zone of danger and the doctor owes a duty to each); *Hyland* v. *State*, Superior Court, judicial district of Hartford–New Britain at Hartford, Docket No. CV 91-0398956S (August 2, 1992, *Aurigemma, J.*) (7 Conn. L. Rptr. 222, 223) (to characterize a mother as a bystander at the birth of her child is most troublesome and seems repugnant to logic); *Smith* v. *Humes*, Superior Court, judicial district of Stamford–Norwalk at Stamford, Docket No. CV 950143884S, 1997 Conn. Super. LEXIS 2018, *9 (July 22, 1997, *Ryan, J.*) (the mother is an active participant in the birthing of a child and to hold otherwise "defies logic and reasoning"); *Manville* v. *Williams*, Superior Court, judicial district of Tolland at Rockville, Docket No. CV 97 65055S, 1998 Conn. Super. LEXIS 1016 (April 8, 1998, *L.P. Sullivan, J.*) (21 Conn. L. Rptr. 654, 656); *Hannon* v. *CCWC Professional Practice Group*, Superior Court, Judicial District of Danbury, Docket No. DBDCV196029568, 2020 Conn. Super. LEXIS 694, *6 (March 17, 2020, *Brazzel-Massaro, J.*) ("it is illogical to find that the mother giving birth would not be an integral participant of the process"); *Krayeski* v. *Greenwich Hospital*, Superior Court, judicial district of Stamford, Docket No. FSTCV146022177S, 2015 WL 9595345 at *7, 2015 Conn. Super. LEXIS 2977 at *16-23 (November 24, 2015, *Povodator, J.*) (61 Conn. L. Rptr. 420) ("the mother is a biologically-necessary participant in childbirth, and there is only one such individual with that status in any given childbirth event"); *Jensen* v. *Physicians for Women, P.C.*, Superior Court, judicial district of Danbury, Docket No. DBDCV146014317S, 2015 Conn. Super. LEXIS 3239, *4 (September 30, 2015, *Ozalis, J.*) ("a birthing mother is the patient and active participant, not a bystander in connection with the delivery of her child"); *Sarfo-Darko* v. *Carraba*, Superior Court, judicial district of Hartford, Docket No. HHDCV055000930S (June 30, 2006, *Tanzer, J.*); *Luminati* v. *Jaffe*, Superior Court, judicial district of Litchfield, Docket No. LLICV065001244S (October 29, 2007, *Marano, J.*); *Smith* v. *Ronan*, Superior Court, judicial district of Ansonia-Milford at Derby, Docket No. CV065000430S (May 22, 2008, *Ripley, J.*); *Brown* v. *Guinan*, Superior Court, judicial district of Hartford, Docket No. CV054012679S (January 14, 2009, *Langenbach, J.*) (47 Conn. L. Rptr. 85); *Best* v. *CCWC Professional Practice Group, LLC*, Superior Court, judicial district of Danbury, Docket No. DBD CV 186025335S, 2019 Conn. Super. LEXIS 2586, 2019 WL 5300182, *3–4 (September 23, 2019, *D'Andrea, J.*); *Gambacorta* v. *Williams*, Superior Court, judicial district of Hartford, Docket No. HHDCV176077609S, 2021 Conn. Super. LEXIS 12, *6-7 (January 8, 2021, *Noble, J.*).

The court has found that Ms. Monroe-Lynch was infected with CMV through the IUI procedure performed at CARS, which also infected her twin children. Upon the death of Shay, Ms. Monroe-Lynch was required to undergo surgery for the removal of Shay's body and the birth of her severely disabled child, Joshua, who was immediately taken away from her to the NICU for his care and safety. Although Ms. Monroe-Lynch has a history of pre-existing mental health diagnoses and treatment, her presentation for mental health treatment is found to be related to the suffering of Joshua and the death of Shay. The court therefore awards her related, past medical expenses claimed of $197,897.53, subject to General Statutes § 52-225a, as well as non-economic damages in the amount of $500,000.

2. Filial Consortium[249]

Ms. Monroe-Lynch and Mr. Lynch seek damages for the loss of filial consortium resulting from Shay's untimely death and in the loss of Joshua's full society and fellowship, now impaired by his debilitating neurological illnesses, as described, supra. The Supreme Court has recently recognized this cause of action, generally, in *Campos* v. *Coleman*, 319 Conn. 36, 123 A.3d 854 (2015), but limited the holding to a child's loss filial consortium upon the death of a parent.

The court concludes that in overruling *Mendillo* v. *Board of Education*, 246 Conn. 456, 717 A.2d 1177 (1998), the *Campos* court recognized that the bond of a child with a parent is not too derivative or attenuated to deny a compensable injury.[250] The court also concludes that the

[249] Although these legal causes of action were generally opposed in the defendant's brief, they were not opposed specifically upon the legal theory asserted by the plaintiffs in Counts 5 through 8 and 14-15.

[250] "Although we acknowledge that strong emotional attachments frequently arise in all of these [family] relationships, we do not agree that the relationships 'present equally strong claims of

reverse is true, that the bond between a parent and their child is not too derivative or attenuated to deny a compensable injury. Although the relationships between parents and their children and vice-a-versa, as well as spouses, are distinguishable by the nature of their reliance upon one another, they are no less important than other foundational, human relationships upon which we rely for our well-being and purpose. In reaching this conclusion, the court follows the well-reasoned rational for doing so set forth in the recent superior court case of *Perez* v. *Stanford*, Superior Court, judicial district of Hartford, Docket No. HHDCV196117765S, 2021 Conn. Super. LEXIS 113 (January 19, 2021, *Budzik, J.*).[251]

---

loss of consortium' as those arising from the relationship between a minor child and a parent. . . . Almost by definition, the familial relationships referred to in *Mendillo* are more attenuated and derivative than the parent-child relationship because the relationship between siblings, between a grandparent and a grandchild, and between an uncle or an aunt and a niece or a nephew arises through the parent-child relationship. Indeed, [t]he parent-child relationship is . . . the wellspring from which other family relationships derive. . . ." (Citations omitted.) *Campos* v. *Coleman*, 319 Conn. 36, 44, 123 A.3d 854 (2015).

[251] "The Connecticut Supreme Court's analysis in *Campos* v. *Coleman*, 319 Conn. 36, 123 A.3d 854 (2015), demonstrates that the time has come for Connecticut to allow such a cause of action. Prior to Campos, Connecticut did not recognize a common-law claim for loss of parental consortium, i.e., a child suing for loss of consortium with an injured parent. See *Mendillo* v. *Board of Education,* 246 Conn. 456, 717 A.2d 1177 (1998), overruled by *Campos* v. *Coleman*, 319 Conn. 36, 123 A.3d 854 (2015). After *Mendillo* was decided, nearly all Connecticut superior courts concluded that claims for loss of filial consortium were also barred by application of the *Mendillo* court's analysis. See, e.g. *Durante* v. *Mohegan Tribal Gaming Authority*, Mohegan Gaming Disputes Trial Court, Docket No. GDTC-T-10-104-FOE (August 2, 2012, *Eagan, J.*) (12 Am. Tribal L. 235) (listing, discussing cases). Before *Mendillo* was decided, Connecticut superior courts were split on whether to allow a claim for loss of filial consortium. See, e.g., *Delvalle* v. *Goggins*, Superior Court, judicial district of Waterbury, Docket No. CV-95-0128043-S, (October 11, 1996, *Peck, J.*) (18 Conn. L. Rptr. 32) (listing cases). Now that *Campos* has overruled *Mendillo*, the Perezes argue that application of the *Campos* analysis demonstrates that it is again time for Connecticut courts to allow common-law claims for loss of filial consortium. This court agrees. As even the *Mendillo* court recognized, "there is nothing in reason to differentiate the parent's loss of the joy and comfort of his child from that suffered by the child. *Mendillo* v. *Board of Education*, supra, 246 Conn. 485 n.20; see also *LeBlanc* v. *Vitam Youth Treatment Center*, Superior Court, judicial district of Stamford-Norwalk at Stamford, Docket No. CV-95-0148611-S (May 9, 1997, *Nadeau, J.*) (19 Conn. L. Rptr. 485) (holding that 'it [is] difficult to see how our state can logically recognize claims of loss of spousal consortium but not of parental loss of filial consortium'). . . . In recognizing a claim for loss of parental

Some superior courts have declined to extend filial consortium to instances of wrongful death. See *Vincent* v. *Yale New Haven Health Services Corp.*, Superior Court, judicial district of New London, Docket No. KNLCV186035007S, 2018 Conn. Super. LEXIS 5887, *3 (December 27, 2018, *Murphy, J.*) ("[t]here has been no similar enactment for postmortem loss of parental or filial consortium claims, despite the recent recognition of a common-law loss of parental consortium claim by our Supreme Court in *Campos* v. *Coleman*"); *Zamora-George* v. *Yale New Haven Hospital, Inc.*, Superior Court, judicial district of New Haven, Docket No. CV196087777S, 2020 Conn. Super. LEXIS 369, *6-7 (February 21, 2020, *Ozalis, J.*) ("*Campos* did not recognize or create a new cause of action for post mortem loss of filial consortium and that the decision in *Campos* is limited to the loss of consortium due to injury"). The claim of filial consortium, however, was not specifically opposed by the defendants on this legal basis.

The wrongful death statute does not specifically identify or exclude claims for consortium, generally; however, the court considers the language of the statute broad enough to encompass such a claim for the death of Shay. The court again cites General Statutes § 52-555 (a), which provides, in relevant part: "In any action surviving to or brought by an executor or

---

consortium, the *Campos* court went through a two-step analysis. First, the court considered those public policy factors favoring recognition. *Campos* v. *Coleman*, supra, 319 Conn. 41-43. Second, the court addressed countervailing public policy considerations counseling against recognition of the claim. Id., 44-57. Both the *Mendillo* and *Campos* courts found merit in the public policy considerations favoring recognition of the claim. Id., 41, 43. Nevertheless, whereas the *Mendillo* court ultimately found that the countervailing public policy considerations outweighed those factors favoring recognition, the *Campos* court concluded that those 'concerns were overstated' and recognized the claim for loss of parental consortium. Id., 43. Using this same two-step process to evaluate claims for loss of filial consortium, and applying the same conclusions that the *Campos* court found to be 'compelling reasons to recognize ... a cause of action [for loss of parental consortium]'; Id., 43; this court concludes that a common-law claim for loss of filial consortium should be recognized in this case." *Perez* v. *Stanford,* Superior Court, Judicial District of Hartford, Docket No. HHDCV196117765S, 2021 Conn. Super. LEXIS 113, *1-5 (January 19, 2021, *Budzik, J.*).

administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages . . . ." The court concludes that the term "just damages" does not exclude consortium claims, leaving that term to be applied by the trier of fact.

Permitting filial consortium claims involving wrongful death is consistent with the more modern view of the nature of consortium. "At common law, the principal marital rights of the husband and, by extension, the core components of a loss of consortium claim, were (1) the household services of the wife, and (2) her sexual relations. . . . During the early 1900s, the concept was expanded in America to include the loss of a spouse's love, affection, and companionship, as well." (Citations omitted.) *Ashmore* v. *Hartford Hospital*, 331 Conn. 777, 810–11, 208 A.3d 256 (2019).

Consortium claims are generally permitted in medical malpractice matters involving the death of a spouse, limited to no more than the underlying award for non-economic damages. Id., 814. ("[W]e conclude that the jury could not reasonably have found on this record that the plaintiff's lost consortium was substantially more damaging than the decedent's loss of life and all of its enjoyments"). The same ought to be true in matters involving filial consortium.

Although spousal consortium claims are permitted by statute post mortem,[252] as in Ashmore above, the common law has not been extended to include such filial consortium claims. Although the court finds *Campos* applicable to Joshua by analogy, the same is not yet true under

[252] General Statutes § 52-555a provides: "Any claim or cause of action for loss of consortium by one spouse with respect to the death of the other spouse shall be separate from and independent of all claims or causes of action for the determination of damages with respect to such death."

our common law for Shay. In its motion for reconsideration, the defendant's correctly points to the *Campos* court's specific limitation on most-mortem filial consortium claims. "We . . . conclude that loss of parental consortium claims are limited to claims resulting from a parent's injury during the parent's life." *Campos* v. *Coleman*, supra, 319 Conn. 59-60. In applying the reasoning of *Campos* to the present matter, filial consortium is inapplicable to Shay under the common law.

Based upon the foregoing, the court awards damages for filial consortium, as follows:

Counts 5 & 14 – Mr. Lynch for lost consortium with Joshua: $2,000,000

Counts 7 & 15 – Ms. Monroe-Lynch for lost consortium with Joshua: $2,000,000

VII

MOTION TO DISMISS

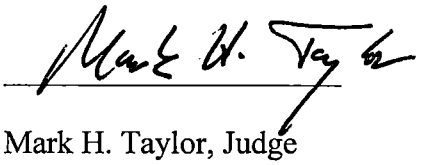
For the reasons set forth in subsection IV A, inter alia, the motion to dismiss is denied.

VII

CONCLUSION

The court finds for the plaintiff on all counts, except count 6, 8 and 16. As set forth in the decision, the court finds that economic damages total $24,121,026.53. The court further finds fair, just and reasonable non-economic damages in the amount of $12,500,000 for a total judgment of $36,621,026.53.

BY THE COURT



Mark H. Taylor, Judge

CHECKLIST FOR CLERK

Docket Number CV 16 6067438

Case Name Lynch PPA, Et Al v. State of Conn. Et Al.

Memorandum of Decision dated Corrected and Reconsidered 8/27/21

File Sealed: yes_____ no X

Memo Sealed: yes_____ no X

This memorandum of Decision may be released to the Reporter of Judicial Decisions for publication. X

This Memorandum of Decision may NOT be released to the Reporter of Judicial Decisions for publication. _____

Superior Court Case Look-up
Civil/Family
Housing
Small Claims
-
Attorney/Firm Juris Number Look-up
-
Case Look-up
By Party Name
By Docket Number
By Attorney/Firm Juris Number
By Property Address
-
Short Calendar Look-up
By Court Location
By Attorney/Firm Juris Number
Motion to Seal or Close
Calendar Notices
-
Court Events Look-up
By Date
By Docket Number
By Attorney/Firm Juris Number
-
Legal Notices
-
Pending Foreclosure Sales
-
Understanding
Display of Case Information
-
Contact Us

Comments

HHD-CV16-6067438-S MONROE LYNCH, JOSHUA ISAAC, PPA AARON LYNCH AND JE Et Al v. STATE OF CONNECTICUT Et Al

Prefix: HD5 **Case Type:** T28 **File Date:** 04/13/2016 **Return Date:** 04/26/2016

Case Detail | Notices | History | Scheduled Court Dates | E-Services Login | Screen Section Help | Exhibits

To receive an email when there is activity on this case, click here.

Information Updated as of: 08/27/2021

Case Information

Case Type: T28 - Torts - Malpractice - Medical
Court Location: HARTFORD JD
List Type: COURT (CT)
Trial List Claim: 06/04/2020
Last Action Date: 08/20/2021 (The "last action date" is the date the information was entered in the system)

Disposition Information

Disposition Date: 06/28/2021
Disposition: JUDGMENT AFTER COMPLETED TRIAL TO THE COURT FOR THE PLAINTIFF(S)
Judge or Magistrate: HON MARK TAYLOR

Party & Appearance Information

Party		No Fee Party	Category
P-01	**JOSHUA ISAAC MONROE LYNCH PPA AARON LYNCH AND JEAN-MARIE MONROE-LYNCH** **Attorney:** WALSH WOODARD LLC (412145) File Date: 04/13/2016 527 PROSPECT AVENUE WEST HARTFORD, CT 06105		Plaintiff
P-02	**AARON LYNCH AND JEAN- MARIE MONROE-LYNCH ADMINISTRATOS OF THE ESTATE OF SHAY ASHLAN MONROE LYNCH** **Attorney:** WALSH WOODARD LLC (412145) File Date: 04/13/2016 527 PROSPECT AVENUE WEST HARTFORD, CT 06105		Plaintiff
P-03	**AARON LYNCH** **Attorney:** WALSH WOODARD LLC (412145) File Date: 04/13/2016 527 PROSPECT AVENUE WEST HARTFORD, CT 06105		Plaintiff
P-04	**JEAN-MARIE MONROE-LYNCH** **Attorney:** WALSH WOODARD LLC (412145) File Date: 04/13/2016 527 PROSPECT AVENUE WEST HARTFORD, CT 06105		Plaintiff
D-01	**STATE OF CONNECTICUT** **Attorney:** O'BRIEN TANSKI & YOUNG LLP (029915) File Date: 04/26/2016 500 ENTERPRISE DRIVE SUITE 4B ROCKY HILL, CT 06067		Defendant
D-02	**CLAUDIO BENADIVA MD** *REMOVED*		Defendant
D-03	**CENTER FOR ADVANCED REPRODUCTIVE SERVICES, P.C.** *REMOVED*		Defendant
D-04	**IN VITRO SCIENCES, INC.** *REMOVED*		Defendant
D-05	**CALIFORNIA CRYO REPRODUCTIVE TISSUE SERVICES** Non-Appearing.		Defendant - Apportionment
D-06	**CALIFORNIA CRYOBANK LLC** **Attorney:** STOCKMAN O'CONNOR CONNORS PLLC (439250) File Date: 11/21/2017 10 MIDDLE STREET 11TH FLOOR BRIDGEPORT, CT 06604		Defendant - Apportionment
D-07	**CALIFORNIA CRYOBANK STEM CELL SERVICES LLC** **Attorney:** STOCKMAN O'CONNOR CONNORS PLLC (439250) File Date: 11/21/2017 10 MIDDLE STREET 11TH FLOOR BRIDGEPORT, CT 06604		Defendant - Apportionment

D-08 CRYOBANK HOLDING LLC Defendant - Apportionment

Attorney: ☍ STOCKMAN O'CONNOR CONNORS PLLC (439250) File Date: 11/21/2017
10 MIDDLE STREET
11TH FLOOR
BRIDGEPORT, CT 06604

Viewing Documents on Civil, Housing and Small Claims Cases:

If there is an ☍ in front of the docket number at the top of this page, then the file is electronic (paperless).

- Documents, court orders and judicial notices in electronic (paperless) civil, housing and small claims cases with a return date on or after January 1, 2014 are available publicly over the internet.* For more information on what you can view in all cases, view the Electronic Access to Court Documents Quick Card.
- For civil cases filed prior to 2014, court orders and judicial notices that are electronic are available publicly over the internet. Orders can be viewed by selecting the link to the order from the list below. Notices can be viewed by clicking the **Notices** tab above and selecting the link.*
- Documents, court orders and judicial notices in an electronic (paperless) file can be viewed at any judicial district courthouse during normal business hours.*
- Pleadings or other documents that are not electronic (paperless) can be viewed only during normal business hours at the Clerk's Office in the Judicial District where the case is located.*
- An Affidavit of Debt is not available publicly over the internet on small claims cases filed before October 16, 2017.*

*Any documents protected by law Or by court order that are Not open to the public cannot be viewed by the public online And can only be viewed in person at the clerk's office where the file is located by those authorized by law or court order to see them.

Motions / Pleadings / Documents / Case Status

Entry No	File Date	Filed By	Description	Arguable
	04/13/2016	P	SUMMONS	
	04/13/2016	P	COMPLAINT	
	04/13/2016	P	ADDITIONAL PARTIES PAGE	
	04/26/2016	D	APPEARANCE Appearance	
	04/28/2016	D	APPEARANCE Appearance	
	08/26/2016	D	APPEARANCE Appearance	
	11/21/2017	D	APPEARANCE Appearance	
100.30	04/13/2016	P	RETURN OF SERVICE	No
101.00	05/11/2016	D	NOTICE Notice of Service of INT RFP - Joshua Isaac PPA	No
102.00	05/11/2016	D	NOTICE Notice of Service of INT RFP - Jean Marie Monroe-Lynch	No
103.00	05/11/2016	D	NOTICE Notice of Service of INT RFP - Aaron Lynch	No
104.00	05/11/2016	D	NOTICE Notice of Service of INT RFP - Admin Estate	No
105.00	05/13/2016	P	REQUEST TO EXTEND TIME TO RESPOND TO INTERROGATORIES OR PRODUCTION REQ P.B. 13-7(a)(2)/13-10(a)(2) as to Joshua Isaac PPA	No
106.00	05/13/2016	P	REQUEST TO EXTEND TIME TO RESPOND TO INTERROGATORIES OR PRODUCTION REQ P.B. 13-7(a)(2)/13-10(a)(2) as to the Estate of Shay Ashlan Monroe Lynch	No
107.00	05/13/2016	P	REQUEST TO EXTEND TIME TO RESPOND TO INTERROGATORIES OR PRODUCTION REQ P.B. 13-7(a)(2)/13-10(a)(2) as to Aaron Lynch	No
108.00	05/13/2016	P	REQUEST TO EXTEND TIME TO RESPOND TO INTERROGATORIES OR PRODUCTION REQ P.B. 13-7(a)(2)/13-10(a)(2) as to Jean-Marie Monroe-Lynch	No
109.00	05/13/2016	P	NOTICE Notice of Request for Admissions - State of CT	No